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ABSTRACT

Historical issues and the development of the mental health personnel system are examined. The four core professions (psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing) evolved into the medical-psychiatric model of the state mental hospitals, institutions for the mentally retarded, and child guidance clinics. This evaluation was a result of social and political forces operating over the past 150 years. Trends in mental health, staff training, and human services which brought about further changes are discussed. Career ladders do not generally exist in areas of mental health and retardation, although moves can be made into administration. Work levels are discussed. A more systematic plan is suggested for interrelationships among mental health professionals and paraprofessionals. (Author/EEF)

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STAFF ROLES FOR MENTAL HEALTH PERSONNEL:
A HISTORY AND RATIONALE

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FOREWORD

The mental health program of the Southern Regional Education Board (SREB) was created in 1954 by a resolution of the Southern Governors Conference to facilitate the development of mental health manpower in the South. The program has engaged in a number of projects related to the training and utilization of the mental health professions and occupations since that time.

Work with middle level workers for mental health began in 1966 with a National Institute of Mental Health (NIMH) supported conference to explore the feasibility of training mental health workers in the rapidly expanding junior colleges. SREB has had several subsequent projects in mental health technology, undergraduate social work, middle level community clinical psychology in addition to projects dealing with the major professions. Throughout all of these activities there has been a growing concern for a rationale through which all of the mental health professions and occupations may be linked into a more harmonious and effective system of service providers. Too often the individual professions and occupations act as if only that one profession was significant in the mental health delivery system. The claims sometimes appear to be extreme and directed toward establishing the group's territory rather than developing a rational delivery system which uses the expertise of all of the groups.

Meanwhile, in the past few decades there have been drastic changes in the mental health delivery system. Few individuals are aware of just how extensive these changes have been for both the delivery system

and the professions and occupations that staff it. "Manpower" issues have usually been considered from the perspective of supply of persons for the individual professions or occupations, with relatively little concern for how they relate to each other to produce an effective delivery system.

As SREB has become involved in additional projects in relation to paraprofessional mental health workers, it has seemed especially desirable to review the recent changes in the mental health delivery system and to suggest a rationale for ways in which all of the professionals and paraprofessionals might best be related in organized delivery programs. In many ways the paraprofessional movement is the least understood component of the delivery system. Yet these persons make up 34 percent of the personnel in the mental health facilities in the United States. This publication considers both "what is" and "what should be" in developing an overall mental health manpower system.

This publication is intended for mental health agency administrators, professionals, paraprofessionals, personnel officers and training program directors for all of the professions and paraprofessions. The projects under which this is being published are supported by the Paraprofessional Manpower Development Branch of the NIMH; grants are T41-MH14439, "Approval of Mental Health Paraprofessional Training Programs" and T41-MH14520, "Certification of Paraprofessional Mental Health Workers." We are grateful for the NIMH support and for the

assistance of Mr. Vernon James and his staff of the Paraprofessional
Manpower Development Branch.

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INTRODUCTION

A number of professions and occupations have evolved over the past century in the mental health manpower system. There has been little overall rationale for the development of these individual professions and occupations or for the ways in which they might best be related to each other and to the clients. Meanwhile the field of mental health has itself evolved from a field that served only the seriously mentally ill and mentally retarded in hospitals and clinics to a field that treats a range of lesser emotional and personality disorders, alcoholism, drug abuse, and family and marital problems. The focus of service has moved from institutions to communities for all aspects of the work--even the long-term care and treatment of the seriously mentally ill and mentally retarded.

Despite all of these changes, the mental health manpower "system" has never been broadly described with a systematic role for each of the different professions and occupations. Each profession has tended to go its own way, generally stressing models of functioning that are more appropriate for independent practice than for organized delivery systems. There have been misunderstandings and turf battles between the professions and between the professions and the occupations as a result of the lack of definition of a scheme for the relationships of the different manpower components in organized delivery programs.

Because the mental health system has so many diverse functions and organizational components it is impossible (and undesirable) to prescribe a template for the ways in which the individual pieces of

the manpower system shall relate to each other. However, it seems desirable to have some overall schema to provide an overall blueprint for how the professions and occupations might better serve the nation's mental health delivery system.

This publication looks at some of the historical issues in the development of the mental health manpower system, the current social pressures on all of the human service delivery systems including the mental health system, some issues in interprofessional relationships, special considerations around the development of career systems with several levels of workers, and makes some general recommendations for what appear to be realistic relationships between all of the manpower components in the mental health and mental retardation delivery systems. It does not explore manpower issues related to the university-based functions of research and training. Nor does it concern itself with the area of independent practice. Several recent studies indicate that the independent practice sector is growing rapidly--especially for psychologists and social workers and to a lesser degree, for nurses--and that many clients are treated by independent practitioners. However, the suggestions in this publication are equally appropriate for organized care settings in either the private or public sector.

These recommendations are not offered in any prescriptive way. They are more in the nature of a road map with several alternative routes. It will be up to each mental health agency's administrator and staff to decide which route that agency wishes to take, but hopefully with a better awareness of the implications of whatever pattern of manpower relationships is chosen than has often been the case in the past.

Chapter 1

BACKGROUND

The mental health personnel system, like the mental health delivery system of which it is a part, has evolved as a result of the social and political forces of the past 150 years; very little of either system has been planned. As a result there is not a coherent program for the present array of professionals and middle level workers. What exists is a relatively productive collection of professions and occupations functioning with lessened efficiency because of friction and poor coordination.

The mental health personnel system in the United States began in the mental hospitals of the nineteenth century. A few small asylums for the care and treatment of lunatics had been created in the early 1800s, but it was not until the 1840s that Dorothea Dix conducted her campaign before the state legislatures to establish asylums throughout the nation so that the mentally ill and mentally retarded could have more humane and enlightened care than they were receiving in the jails and almshouses of the time. She was remarkably successful and more than 20 states established asylums in which the mentally ill and mentally retarded could receive the "moral treatment" of the time and be restored to their families.

Late in the nineteenth century the states began to separate the mentally retarded from the mentally ill, but the same basic personnel patterns prevailed in these "homes" as in the asylums.

THE FOUR CORE MENTAL HEALTH PROFESSIONS

In those early asylums the only truly professional staff persons were the medical superintendents--then called alienists, later, psychiatrists. The patients in the early asylums were almost exclusively psychotic or severely retarded; the milder mental disorders were not recognized nor provided for in those days. Many of the patients suffered from organic psychoses (syphilis of the brain, the dementia of pellagra, alcoholic brain damage, and the most severe forms of mental retardation). Even those patients with functional psychoses (schizophrenia, paranoia and manic-depressive illness) were so disturbed that they seemed to be organically deranged. It was natural that the medical model of treatment emerged and then persisted for so many decades.

Soon, in the medical tradition, those superintendents brought in matrons to provide for the day-to-day care of these patients. The first matrons were not trained nurses, but were dedicated women who worked under the direction of the physicians. Later the matron positions were converted to nursing positions, and a number of state mental hospitals established diploma schools of nursing to train their own nurses so they would not have to depend on general nursing schools in distant cities.

There were no psychologists or social workers in the early days. Psychology was essentially a scientific discipline in its origin. However, in the early 1900s some psychologists began to develop tests of human intelligence and later, of memory and personality. In the 1930s and the forties, especially during and after World War II, the specialty of clinical psychology emerged and took its place in the mental hospitals and child guidance clinics. For years psychologists were largely

restricted to the auxiliary role of carrying out psychological testing under the direct supervision and orders of the physicians. A few clinical psychologists who worked in child guidance clinics or other out-patient clinics were allowed to do therapy, but it was not until the late 1950s that the older pattern was abolished in most mental hospitals and schools for the retarded, although the previous practice of using psychologists as auxiliaries to psychiatrists still exists in some hospitals.

The profession of social work emerged in the late 1800s. Most social workers were employed in urban slums and settlement houses, but others were hired by mental hospitals and clinics. At first these workers were almost entirely restricted to obtaining social histories from families and to working with families regarding patient needs (e.g., for clothing, money, etc.). They also became responsible for making arrangements for families when the doctors decided that the patients were ready to go home. Social workers in mental health settings, like the other professionals, were auxiliaries to the physicians.

A training sequence in psychiatric social work to prepare workers for mental hospital and psychiatric clinic settings developed. Students learned psychodynamics and psychotherapeutic casework skills that were particularly useful in working in child guidance and out-patient settings. However, in the 1950s, when social work education became more generic, the special psychiatric social work sequence was abandoned, but the notion of psychiatric social work still persists for many persons in the field of practice.

Meanwhile, nurses who worked in psychiatric settings felt the need for special training beyond basic nurse training. At first schools of nursing added segments of training devoted to the care of psychiatric patients, but later they initiated master's degree programs for training in psychodynamics and psychotherapeutic skills beyond the basic levels required to become a registered nurse. Initially it was thought that even the master's level psychiatric nurse would work primarily in medical settings under the direction of psychiatrists.

Thus these four core professions, the "big four" of mental health--psychiatry, clinical psychology, psychiatric social work and psychiatric nursing--evolved in the medical-psychiatric model of the state mental hospitals, institutions for the mentally retarded and the child guidance clinics. This was the situation when the National Institute of Mental Health came into being and established support programs for training in each of these disciplines in the late 1940s.

CHANGES IN THE MENTAL HEALTH DELIVERY SYSTEM

Since 1948 there have been remarkable changes in the scope and technology of the mental health system. First came the development of treatment and prevention technologies for some of the most difficult psychosis so that the large numbers of patients with pellagra and syphilis of the central nervous system diminished and then vanished altogether. The most disturbing symptoms of schizophrenia and manic-depressive illness yielded before treatments such as insulin shock and electro-convulsive therapy and then the psychotropic medications. Many states began to reduce their hospital patient census even before the introduction of the tranquilizer medications in 1955, but these new

treatment techniques made dramatic changes in the hospitals. With the florid and disturbing symptoms of mental illness under control, it became possible to institute programs of psychotherapy and rehabilitation in the hospitals. Many of those patients who would ordinarily have gone to the psychiatric units of state or local general hospitals could be managed in small private mental hospitals or in out-patient programs with much shorter periods of treatment and with much less stigma and upheaval in their lives.

Also in the 1950s, the institutions for the mentally retarded began to stress education and habilitation to prepare the mentally retarded to return to the communities and live as near normal lives as possible. A range of special education and social and vocational programs began to be developed in the communities. These community programs stressed educational and behavioral techniques more than medical-psychiatric techniques.

The early 1960s saw the federal endorsement of the community mental health centers movement with emphasis on treatment and rehabilitation of the mentally ill and the mentally retarded in the community. In the late 1960s there were new emphases in treatment of alcohol and drug abuse, which had previously been considered a problem for the criminal justice system, but which now increasingly became regarded as mental health problems.

NEW THERAPIES AND NEW PERSONNEL

During these same years, the community mental health movement and much of the private sector of the mental health system have turned increasing attention to problems of the psychoneuroses, psychosomatic

conditions, personality and character disorders, milder degrees of mental retardation, and problems of family and marital strife. A whole new set of psychological and social "therapies" have come into being to work with these conditions--behavior modification, transactional analysis, desensitization, therapeutic community, family therapy, etc.

In the personnel/manpower area these three events brought major developments:

- *The roles and relationships among the four core professions have been greatly altered.*

No longer is the medical model of the old state hospitals and institutions for the mentally retarded considered to be the only appropriate model for mental health care. Psychologists and social workers have espoused the new therapies and sought positions where they are allowed to practice them. Increasingly, treatment and rehabilitation teams in community settings and even in hospitals are led by disciplines other than psychiatry or medicine. There are now many different team models in addition to the medical model. Many psychologists and social workers have gone into independent practice and into voluntary agencies where they can practice without the specific direction of psychiatry--especially in working with conditions other than the major mental illnesses.

Because there has been no systematic redesigning of the personnel relationships, this broadening and opening up of the fields of mental health and mental retardation has led to considerable role confusion among the professions. The "medical model" is openly criticized in the literature. At the same time, there are behavioral psychologists who claim jurisdiction over certain kinds of cases, and psychodynamically oriented social workers who claim others. Each profession seeks independent licensure and authorization to receive independent vendor payments under third party health payment plans and, ultimately, under whatever form of National Health Insurance will be developed.

These changes in the mental health field to add a wider range of emotional and mental conditions have led to what has been called the "blurring of roles" of the professions. All of the professions are now involved in a variety of counseling techniques with clients; any one of the professions may now be the captain of a team and the individual professionals play interchangeable roles in much of the

system. The medical model still persists in most acute-care hospital settings, but there is considerable variation of models in other parts of the mental health system which depend more on psychosocial and educational and rehabilitative processes than on traditional medical-psychiatric techniques.

- *There has been a considerable increase in the kinds of professions serving the mental health field.*

In the mental health field this began with the introduction of various kinds of counselors--pastoral, rehabilitation and more recently, alcohol and drug abuse counselors. It also includes a range of activity therapists--recreation specialists, occupational and industrial therapists, and a range of instructional professionals, particularly special education teachers for the mentally retarded and emotionally disturbed. Many of these persons are primarily involved in the social, educational and vocational rehabilitation of clients rather than the acute treatment. This reflects the new emphasis in mental health and mental retardation on providing rehabilitation and community restoration services as well as diagnosis and acute treatment. While many of these professionals have been productively employed in mental health and mental retardation programs, there has been relatively little formal recognition of these new professionals as part of the mental health establishment. For the most part they are considered to be ancillaries. They are lumped together in most data systems as "other professionals," but they comprise nearly 12 percent of the direct patient care staff of the mental health field.¹ Many have been trained in academic departments of counseling and guidance or special education rather than in the professional schools of the clinical specialties. The whole area of the use of new professionals needs further study.

- *The introduction and use of new levels of mental health workers--the paraprofessionals.*

This movement has received little systematic attention in mental health. It has been subject to considerable rhetoric proclaiming that the paraprofessionals could replace the professionals despite their short period of training. This kind of talk has led to some professional and public skepticism about paraprofessionals in the delivery system. However, there are now several thousand paraprofessional workers who are employed in the mental health delivery system. They come from many different philosophical and training backgrounds.

BACKGROUND OF MIDDLE LEVEL AND PARAPROFESSIONAL WORKERS IN MENTAL HEALTH AND MENTAL RETARDATION

The development of paraprofessionals and other middle levels of workers in a manpower system that formerly recognized only fully qualified professionals needs greater explanation to understand how these workers may best be integrated into the delivery system.

While the mental health field has long been staffed with the core of professionals already described, in the mental hospitals and institutions for the mentally retarded there have also been large numbers of nonprofessional workers, called attendants or aides, who performed the custodial functions of supervising the wards and providing the basic physical care of patients and residents. These aides were usually given a few weeks of in-service training, but they had no status either in the educational system or in the agency's professional system. There was no way they could move up to professional jobs without quitting and going to school for a full course of professional education. Essentially, there were no middle levels of workers or career systems in the mental health system. Staff persons were either fully qualified professionals or aides with no career opportunities.

In the monograph, *Manpower Trends in Mental Health*,² written for the Joint Commission on Mental Health and Illness in 1959, Dr. George Albee documented the shortages of mental health professionals and the likelihood that there would never be sufficient professionals if the nation persisted in training and using only professionals in the traditional ways. He suggested that it should be possible to train workers for mental health work in a shorter time and more directly than having to train them first in some profession (e.g., medicine, nursing) and

then specialize them in mental health work. Little was done about this recommendation until the mid-1960s when there was the expansion of mental health in the communities through the mental health centers movement, the mental retardation movement, and the community alcoholism and drug abuse programs. With the "Great Society" programs in the late 1960s, the mental health manpower shortages became far more acute and led to activities on many fronts to develop new levels of mental health workers.

Middle Level Workers in the Professions

One response was to develop middle level workers, and efforts were made by individuals within the established professions to set up training programs for practitioners at academic levels just below those normally considered to be the entry level professional degree. Among these efforts were programs to train baccalaureate level social work practitioners and master's degree level clinical psychologists. Social work graduates of baccalaureate programs have been accepted into that profession, but other professions have been more reluctant to give organizational support to middle level practitioners. However, many of these graduates have found jobs in agencies that needed workers with basically adequate training for practice, even if they don't have formal recognition by their professions.

The Paraprofessional Movement

Meanwhile the Scheuer Subprofessional Career Act of 1966 set up a series of "new careers" training programs to be administered by the Department of Labor to train and employ entry level workers for a range of human service programs. In addition to training programs for workers

such as teacher aides, child care workers, and corrections officers, there were several programs to train mental health workers. These were often in-service training programs based in community action agencies and operating mental health agencies, with links to local vocational schools or community colleges. The programs were generally conceived to provide jobs for the poor and underprivileged minority group persons, with careers to be developed later through work experience or in-service education. While a major thrust for paraprofessional workers came from the Scheuer Act, several other paraprofessional programs were developed through other funding sources such as Model Cities and the Office of Economic Opportunity. Because most of these training programs and the related job descriptions were specific to the agencies that created the programs, there was considerable variation among the training programs and the roles and functions the new workers were expected to play.

The National Institute of Mental Health also contributed significantly to the paraprofessional movement. In 1963 it undertook Hospital Staff Development programs in state mental institutions to improve the training of psychiatric aides and attendants as well as other middle level workers. Through its Experimental and Special Training Branch, the NIMH supported other programs to develop training programs for new levels of workers, including the program of Margaret Rioch, a psychologist at Johns Hopkins University, to train middle life women to be mental health counselors and a grant to SREB in 1966 to explore the feasibility of training mental health workers in the rapidly expanding two-year junior (community) colleges. The Experimental and Special Training Branch also funded a number of experimental associate degree and

bachelor's degree programs: Daytona Beach Community College (Florida); the Fort Wayne Extension Program of Purdue University (Indiana); Greenfield Community College (Massachusetts); Jefferson State Junior College (Alabama); Metropolitan State College (Denver, Colorado); Morgan State College (Baltimore, Maryland); Philadelphia Community College (Pennsylvania); and Sinclair Community College (Dayton, Ohio).

Later it funded other projects to SREB, the Western Interstate Commission on Higher Education and the Center for Human Services Research at Johns Hopkins University in addition to short-term developmental grants to approximately 60 other associate degree programs.

In 1970 the NIMH established the New Careers Branch to give specific leadership to the development of entry level training programs for indigenous and disadvantaged persons. In 1975 this branch became the Paraprofessional Manpower Development Branch, charged with leadership for giving sharper definition and development for all levels of paraprofessional workers.

Rationales for the Use of Paraprofessionals

While a major reason given for the training and use of paraprofessional workers was the need to provide jobs for the poor and disadvantaged who had been excluded from human service work because they lacked academic credentials, there were several other reasons given for the introduction and use of paraprofessionals at the entry and technical levels. Among them were:

These workers would be *less costly* than full professionals.

These workers would be *less mobile* than professionals, and thus more likely to remain in agency employment. This was expected

to be especially true for rural area paraprofessionals.

These workers were *indigenous* to the communities they served, and thus would be better able to relate to clients.

These people would perform *functions that professionals do not ordinarily perform*, such as outreach and aftercare.

These workers would be able to *help clients relate to all of the various professions and agencies* that serve them.

These workers would *play advocacy roles* for individual clients and for changes in the system that serves them.

These workers would better *represent community concerns* to the mental health agencies, thus making the agencies more responsive to community needs.

These workers would be able to *perform some of the routine chores of the professionals*, thus freeing them to carry out more "professional" duties.

These persons would be able to *extend the services of the professionals* by working to carry out programs decided upon by professionals.

The programs would provide human service *career opportunities for the disadvantaged* (the poor, minorities and the middle life housewives) who otherwise would be stalled forever in dead-end jobs.

Obviously, not every paraprofessional program subscribed to all of these rationales. And there has been very little broad scale research to measure whether all of these rationales have proven to be effective in operation, just as there is little research to document the effectiveness of the overall mental health manpower system. However, there are several local or limited studies which show that most of these theories have been successfully implemented in certain settings. Perhaps the concepts that have proven to be least likely to become operational are:

There is only a modest cost saving in using these workers in roles similar to those of the professionals, except in comparison to the highest paid professionals, such as M.D.s and Ph.D.s.

System change is very difficult to bring about through paraprofessional workers alone.

It has been difficult to create truly operational career systems in both the agency employment systems and in the educational systems.

Community College Programs to Train Mental Health/Human Service Workers

At the same time that the New Careers movement was developing new workers for the entry level workers, the rapidly expanding community colleges became interested in training a variety of human service workers, including mental health and mental retardation workers who might be educated in one- or two-year programs that would award either a certificate or an associate degree. Since the first such training program was established in 1966 at the Fort Wayne Extension Program of Purdue University, approximately 200 similar training programs have been put into operation in either two-year or four-year colleges and, as of 1977, there have been more than 30,000 graduates. Many of the graduates have gone on to college to continue their studies toward a professional degree, but many thousands are employed in mental health programs and human service settings of almost every conceivable type. A number of these college training programs that began as "mental health" training programs have now changed their title to "human services" because they found that their graduates were being employed by a variety of human service programs outside of the usual mental health system (e.g., juvenile courts, public school counseling services, nursing homes, etc.).

These college-based training programs began with little overall concept of what a Mental Health Technician (or Mental Health Associate) was expected to be and do. Most programs had some kind of advisory committee of local agency people who structured the program objectives in terms of their agencies' needs. Most programs were developed by psychologists, social workers or nurses, and the programs usually were philosophical and technologically oriented toward those professions. Thus there was considerable variation in these early programs, although they all featured the training of a practitioner to work directly with clients and families.

In 1969 the Southern Regional Education Board, supported by a grant from the NIMH, looked at the needs of clients and families who seek help from the mental health system, compared these to the possible models that might be adopted for developing jobs for new workers, and recommended that the "generalist" model be chosen whenever feasible. These findings were published in the document, *Roles and Functions for Mental Health Workers*,³ which has been adopted as a basic training model by virtually all of the mental health/human services technology training programs in the nation. However, there have been various interpretations placed on this concept of the generalist, depending on the individual program's local needs and its leader's orientation. This generalist concept will be explored further in a later chapter.

A problem often arises when workers trained in generic models seek jobs in agencies in which they are expected to perform in more restricted roles. This situation results in frustrations comparable to those formerly experienced by psychologists and social workers in

mental institutions who were restricted to auxiliary activities of psychological testing or taking social histories, despite the fact that they had been trained for much broader functions.

Baccalaureate Mental Health Workers

The past ten years have also seen the development of baccalaureate programs to train mental health practitioners. There are presently approximately 25 such programs with emphases varying from a focus on direct psychological interventions with clients to community mental health administration. However, most feature the training of a generic mental health worker with a strong orientation to community mental health work and to some supervisory or program leadership responsibilities.

In addition to the graduates of such specialized baccalaureate programs in mental health practice, there are large numbers of baccalaureate level persons with majors in the social sciences who were employed during the expanding job market of the late 1960s and very early 1970s. A number of community mental health agencies have established special in-service training programs to teach practice skills to such baccalaureate graduates and have continued to use these persons in the delivery of direct services to clients. Programs of this kind exist at the Rockford, Illinois Zone Center, the Philadelphia State Hospital, and the Georgia Mental Health Institute in Atlanta.

Utilization of Paraprofessionals

The full extent of the use of middle level and paraprofessional workers in the delivery of mental health services is not known because the statistical categories for reporting of these workers have been

poorly defined. However, it is known that in 1974, 33.6 percent of the persons employed in the mental health facilities which report their data to the Office of Biometry of the NIMH had less than a baccalaureate degree. (This excludes nurses and licensed practical nurses). These persons are heavily represented in the institutional facilities where many are undoubtedly psychiatric aides or attendants. Paraprofessionals are no longer used as a stop-gap measure because professionals cannot be found; more and more they are an integral part of the mental health delivery system.

Studies such as those of Sobey, the Southern Regional Education Board and Young, True and Packard^{4,5,6} have shown that paraprofessionals have been employed in virtually every kind of community and institutional mental health and mental retardation program. These programs include alcohol treatment, aging, mental retardation, child treatment, consultation and education, day care, drug abuse, crisis and emergency, aftercare, in-patient and out-patient treatment for the mentally ill, screening, and custodial care programs.

Paraprofessionals are engaged in a similarly broad range of activities. The study by Young, True and Packard identified the following activities that were performed "much or some of the time" by 50 percent or more of a sample of 106 technical level (workers with associate degrees) mental health workers.

- conducts intake interviews
- gathers information on patients' immediate life situation
- records history/background information on patients
- makes recommendations for treatment, discharge, followup

- does individual therapy
- motivates patients to improve
- carries out milieu therapy
- works with families of patients
- keeps patient records
- participates in team/staff meetings
- schedules appointments/meetings
- serves as spokesman for patients in relation to treatment staff
- helps patients obtain legal, financial or other assistance

Other activities that were performed by 25 percent or more of these workers were:

- carries out activity therapies
- takes crisis calls or sees walk-ins
- orients patients to treatment settings and treatment plans
- teaches patients specific skills
- uses behavior modification techniques
- conducts ward meetings
- aids patients and families upon discharge
- reports back to treatment team on patient's progress
- consults with schools, etc.
- locates and develops community resources
- supervises other workers

In addition, there were smaller percentages of workers who reported such activities as:

- administers psychological tests

- takes temperatures and blood pressures
- administers drugs
- conducts workshops
- assists in research projects
- conducts in-service training programs

This study of Young, True and Packard also obtained the ratings of supervisors regarding how well these workers performed these activities. In nearly all cases 70 percent or more were rated as "excellent or good." In all of the direct care activities 90 percent or more of the workers were rated as "satisfactory" or better by their supervisors. Lower ratings were given for such work as research, supervision and community development.

Results similar to these were reported for paraprofessional workers in a study of community mental health center functions conducted by the University Research Corporation for the National Institute of Mental Health in 1975-76.⁷

SHORTCOMINGS IN THE DEVELOPMENT OF THE PARAPROFESSIONAL MOVEMENT

Many of the paraprofessional programs trained workers for specific functions, such as outreach, aftercare, intake or advocacy, while other programs trained workers for much more generalized roles with clients. Still others trained workers to be aides to one or another of the established professions; some were entirely hospital or institution oriented, while others were exclusively community-based. There were many possibilities and virtually every possible model was chosen by

some program. An overall social movement requires a degree of consistency along with local variations; the consistency needs greater definition.

A major shortcoming of many paraprofessional training programs has been the failure to define how these new workers would be related to the other personnel of the agency and how they might advance in a career course. As a result, many workers found themselves shunned by the professionals and employed in what were essentially dead-end jobs. Because the pay scales were likely to be low, these programs often experienced high attrition rates.⁸ Advancement, even when career ladders have been defined, have been slow for most paraprofessionals.

Some of the rhetoric of the paraprofessional movement has been antagonistic to the values of the established professions and agencies. Talk of systems change, talk of replacing of professionals and talk of fighting the vested interests of the professions have made some persons suspicious and skeptical of the paraprofessional movement. What needs to be developed is a productive relationship between the paraprofessionals and the professionals--not a substitution.

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Chapter 2

TRENDS IN MENTAL HEALTH AND HUMAN SERVICE PERSONNEL

The mental health/mental retardation system is one of several human service programs serving people in situations both of crisis and disability and of normal growth and development. It has become apparent that all of the human service programs must be considered together. They have the same overall goals; they serve essentially the same clients; they use many of the same personnel; and they are likely to be funded by the same public funds. They differ mainly in the area of people's lives which they address or in the organizations in which they are located by historical precedent, but even then, there is much that is common in the services they render. The programs that are usually considered to comprise the human services are social services, family, children and youth services, general health, public health, mental health, mental retardation, alcoholism, drug abuse, aging, corrections, criminal justice, vocational rehabilitation, child care, therapeutic recreation, and sometimes, special education. Because of the many common characteristics and problems, many states and cities have organized several of these programs into combined human resources agencies.

HUMAN SERVICE TRENDS

There are several common trends in the developing patterns of the service delivery systems and the manpower systems for all of the human services, including mental health.

- *Community based services*--Virtually all of the human services are moving toward providing services to their clients (or patients) in the communities where the clients live rather than in distant institutions. This is as true of corrections and youth services as it is of mental health and mental retardation. The push for deinstitutionalization is being fueled by court orders requiring the "least restrictive alternative" for clients.

In terms of personnel, this will require dispersal to smaller communities and rural areas and to all areas of the cities--inner cities and ghettos as well as medical centers and suburbs.

- *Independent social living for clients*--Not only is there a trend to move the services to the communities, but there is a move to normalize the living conditions and to maintain the clients in as independent a living situation as possible. There is growing alarm about unnecessary hospitalization or nursing home care, even at the community level, if other arrangements can be made.

This will require more personnel trained in outreach and after-care to provide the necessary community support services for these clients to maintain their independent social living. It does not seem reasonable that these support providers should be expert professionals. Rather, they should be workers who are broadly prepared to help their clients with all aspects of living--housing, finances, health, employment, family life, recreation, etc. Obviously, these workers will not be experts in all of these areas; for high levels of expertise, they will need ready access to consultation and support from specialists. Nor will it be the responsibility of any one agency to provide all of these services itself, but it will be the responsibility of each major program agency to provide the continuity of care for its own long-term clients and to help them link up to the other services.

- *Client self-determination*--Another trend that is widely accepted in all of the human services today is the notion that the client has the right to determine what happens to him. The right of self-determination is also being affirmed by court decrees. This has many aspects--the right of informed consent, the right to refuse treatment, the right to choose from treatment alternatives, etc. Increasingly clients are turning to self-help groups, to indigenous workers like themselves, and to persons who will provide services at more convenient times and places than has sometimes been the case in the past.

The personnel implications here are not so clear, but it is likely to mean that clients will demand more workers like themselves whom they can trust to consult with professionals and

advise about services or to refer them to appropriate professionals when special services are needed. These workers will be expected to be the clients' agents and advocates to plead for the services the clients need in ways that the clients determine are best for them.

- *Use of self-help groups and volunteers*--The past 20 years have seen a great increase in the number of self-help groups and volunteer workers. Self-help groups sometimes are formed to provide mutual support and education for their members (e.g., Alcoholics Anonymous, TOPS (Take Off Pounds Sensibly), Parents Without Partners, Recovery, Inc.) and sometimes to be advocates for their constituents (e.g., National Association for Retarded Citizens, Gay Rights Alliances).

While some of these self-help groups have been instigated by professionals, more often they have been initiated by persons with the problems and there is a considerable anti-professional tone to their activities. They are more likely to have originated from community action programs where paraprofessionals have been active in creating awareness and in motivating group action.

- *Employment of new levels of workers*--Virtually all of the human services have begun to employ new levels of workers in addition to fully qualified professionals. In many programs this includes employment of former recipients of services. This is partly the result of manpower shortages a few years ago and partly because of a new awareness that, appropriately used, paraprofessionals, especially persons from disadvantaged groups and former recipients of services, have a ready rapport and understanding of the culture and problems of the clients which improve the effectiveness of the overall delivery system. Paraprofessionals are considered to be a permanent part of the human service delivery system. A recent study of the use of paraprofessionals in human service work in the Seattle area estimates that there are more than 800,000 paraprofessionals employed in human service work in the United States.^{1,2}

In general, the human services, like the rest of the employment system, has developed four levels of workers:

1. *The entry level*--Persons with no job-specific training prior to entering employment, but who perform the most common work of the field under rather close supervision or under carefully prescribed conditions. These persons are often in training or probationary positions.
2. *The technical level*--Persons with some specific training for their work who perform the ordinary work of the field

under general supervision. They may have a certificate or an associate degree or they may have only in-service training and a considerable period of successful work experience.

3. *The associate professional level*--Persons who perform the ordinary and some extraordinary work of the field under professional supervision. They often have the approximate equivalent of a bachelor's degree with specific training to practice in the field or considerable work experience in the field.
4. *The specialist or professional level*--Persons who perform both ordinary and extraordinary work of the field and most often have advanced professional training.

More will be said about these levels in a later section.

- *Development of career systems*--Several of the human service systems are beginning to develop career programs whereby workers who enter the system at any level can move up in the system on the basis of advanced competence. Formerly most of the human services, including mental health and mental retardation, had only entry-level positions (e.g., aides, attendants, guards) and full professionals. There were no career systems. Virtually all of these career systems are in the early stages of development, but they usually include ties to educational programs for either in-service or continuing education training to help the employees increase their competence.
- *Titling and describing jobs by function or field*--In all of the human services there is an increasing trend to title and describe jobs according to the functions the workers perform or the field in which they work rather than according to a traditional professional title. Sobey found that 52 percent of the workers in her study carried non-traditional job titles.³ This is especially true in smaller community-based agencies. Thus, positions are more likely to be titled "outreach worker," "aftercare worker," "corrections worker," "mental health worker," "aging program worker," or even "human services worker," rather than "social worker," "nurse aide," or "psychology assistant." This reflects the more functional character of many of today's job formulations.
- *Stress on competence, not academic degrees*--Agencies are coming to realize that effective human service work depends on competent performance rather than on academic degrees. Qualities such as

empathy and genuineness have been demonstrated by Truax and Carkhuff to be key elements in establishing effective interpersonal relations and are often as important in obtaining good results with clients as the specific techniques of intervention.⁴ These characteristics, along with good motivation and a value orientation to client service, may be developed by persons at any level of employment. These qualities are as likely to provide the basis for favorable supervisor ratings and promotions as academic degrees or years in employment.

This trend, like most of the other personnel trends previously mentioned, is more likely to be seen in smaller, community-based programs than in the large state bureaucracies. Often community-based programs, such as day care programs, satellite centers, halfway houses, sheltered workshops and counseling programs, are contract agencies of the large bureaucracies, so that their personnel practices are not limited to the formal requirements of the state Merit Systems which are often locked into more traditional personnel policies and procedures.

From all of these trends in the human service delivery system there are several conclusions:

While the expertise of professionals is still desired, it is no longer being held in the same awe and authority that it once was.

In community programs a variety of workers without academic credentials are being used to carry out functions in ways that clients find comfortable and useful.

The focus of services is on helping the client to function better in his community rather than on highly specialized treatment services with elaborate bureaucracies. Clients are involved in determining what happens to them and who serves them.

SPECIAL CHARACTERISTICS OF HUMAN SERVICE WORK

The objectives for utilization of personnel in all of the human services is to help individuals to function better. This has two major aspects:

- *Working with persons in groups to educate them or to prepare them to better cope with some aspect of their lives.* This is essentially a developmental process in which the worker uses himself/herself and

his/her knowledge to increase the group's capacity to anticipate and solve problems. It is the essence of much preventive work in the broad human services as well as the main mission of education.

However, success depends on the use of relatively small groups of persons to whom the human service worker can relate in an active and personal way. The worker must engage, motivate and stimulate the class or group to learn and develop. The personal characteristics of the teacher or worker become as important in some ways as the specific knowledge or skills. There are many examples in health education and in general education for social living in which instructors without these characteristics have been unable to motivate changes in behavior in their clients despite the fact that their knowledge and teaching techniques were apparently correct.

- *Working with clients as individuals to help them in trouble, in crisis, or in disability to resolve their problems or better cope with their disability.* This clinical work requires an individual worker to relate to each individual client, or at most a very small group of clients, to help the client understand the problem(s) and to adopt more productive patterns of behavior and find other sources of help. Work with individual clients cannot be mass-produced like products in industry. Here too, the personal characteristics of the worker are important in obtaining favorable outcomes.

Effective human service work differs from the manufacture of products in that it depends on the client's participation and cooperation in the process. The client must be motivated to do some things himself (e.g., take his medicine, lose weight, stop smoking, learn a new skill, try a new pattern of reacting to people) for there to be a favorable outcome. The client has a significant role in the process unlike an object moving passively down the assembly line in industry where each worker carries out a narrow technology according to a predetermined plan.

Some of the human services, especially the acute health and mental health care systems, have greatly increased the number of specialized professionals and technicians who work with each client/patient. This has led to considerable criticism and concern about the de-humanization of medical care--especially in hospitals. It also seems to have led to increasing non-compliance and distrust of the health care system and talk of wanting to go back to the days of the family doctor who maintained a closer and more personal relationship with patients.

Manpower studies in the human services have generally ignored this element of the client's need to understand and feel good about the worker and the procedures in order to comply and be motivated to actively participate in activities which are necessary to obtain the desired outcomes. Studies have focused, as in industry, almost

entirely on the workers and the work they do, thus excluding the client--the most important element of all.

These factors, the *individualized nature of most human services* and the need to cultivate the client's involvement and to find ways to motivate the client to progress are critical in distinguishing manpower utilization in the human services from manpower use in the manufacture of hard goods and most other service industries. These factors have important implications for the ways in which staff should be organized and utilized.

TRENDS IN MENTAL HEALTH PERSONNEL UTILIZATION

For the most part, the mental health system is experiencing the same general trends and manpower development patterns as the other human services, but it differs somewhat because of certain characteristics of the field:

- *The mental health system overlaps both the health field and the social welfare field and has certain significant traits of each.* Acute psychiatric illness and the organic mental disorders quite clearly belong in the health care field where the medical model and other characteristics of the acute health care field apply. At the same time, problems or marital conflicts, family strife, personality disorders, and situational adjustments are likely to be conceived as psychosocial problems more closely related to the social welfare field. The mentally retarded, after the point of diagnosis, seem to belong more to the educational and social rehabilitation fields than to the health fields. The long-term mentally ill also require social support and educational programs rather than programs of acute psychiatric treatment.

Psychoneurotic disorders provide a middle ground since they are treated with psychological rather than with either purely medical or purely social therapies. Many types of mental illness, alcoholism and drug abuse require both a period of acute medical-psychiatric care and a period of psychosocial counseling and rehabilitation.

In the acute health care aspects of mental health work there must be psychiatrists who establish the diagnosis, prescribe the medication and generally direct the treatment program. This

responsibility cannot legally or therapeutically be avoided. In addition, third party payment programs require it. In such situations the roles and relationships of the medical model are relatively clearly established.

The need is for organized care systems that shift the clients who no longer require medical-psychiatric care on an intensive basis to teams that can provide the necessary range of psychosocial, rehabilitative and social support services, while still retaining psychiatric services as needed. Many client/patients require maintenance medications over a period of weeks or months while they undergo intensive programs of counseling, rehabilitation and adjustment of their social living arrangements. For these cases, the psychiatrist must provide the supervision of the medication, but it is usually more appropriate for other workers to carry out the remainder of the person's rehabilitation and aftercare than for the psychiatrist to continue in charge of every aspect of the case. The questions of how to make this transition have implications for personnel management.

- *The newer psychosocial therapies and their variations provide a range of interventive techniques that are neither specific to certain kinds of clients nor specific to certain professions. The choice of intervention rests more on the particular array of problems of the client and the experience and judgment of the individual worker regarding what works best in his or her hands. Research by Frank and others has shown that the results of certain therapies are more quickly or more surely obtained than other behavioral therapy and short-term psychotherapy is often as effective as long-term psychotherapy at less cost.⁵ This does not mean that all skills of intervention are not important, but it requires that special attention be given to the specific therapy to be used in whatever pattern of personnel deployment and utilization is chosen.*
- *The long-term care needs of the chronically mentally ill and mentally retarded require more educational support activities than either medical services or psychological services. Many of these persons have passive and withdrawn personality characteristics which require that workers reach out to keep in touch with them, since they are unlikely to initiate and maintain contacts with the human services delivery system on their own. This is in contrast to the typical expectation in acute mental health care in which the clients initiate the therapeutic relationship and are expected to maintain a schedule of appointments until the therapy is formally terminated.*

In addition, these long-term clients are likely to have problems in several other practical aspects of their lives--housing, economic security, recreation, etc. The mental health worker who works with

them must be prepared to help with these practical needs as well as with psychosocial problems. One reason that deinstitutionalization programs have been criticized in several states is that the mental health aftercare programs have largely ignored these daily living problems of the clients who have been placed in boarding homes and rooming houses. The mental health system must assume responsibility for helping these persons to establish and maintain linkages with other systems, to continue taking their medication and to adhere to an appropriate and meaningful life. It is not sufficient for the mental health system to provide only medication and traditional out-patient care for these clients. This is the theme of the Community Support System program recently announced by the National Institute of Mental Health.⁶ This program calls for the use of generic case managers to carry out these follow-up and linkage roles.

- Despite the mandates of the Community Mental Health Centers legislation for community mental health centers to carry out *programs of consultation, education and community planning* for purposes of prevention and improved public understanding of mental disorder, there has been much too little of this work done. Surveys show that less than five percent of the professional staff time of most community mental health centers is devoted to consultation and education activities. This is partly because of difficulties in funding, but it also represents problems in having personnel trained and deployed to carry out these activities. The training for virtually all of the mental health professions and occupations is focused on the diagnosis and treatment of persons in crisis or disability so that mental health professionals are both ill prepared and disinclined to do preventive and educational work.
- *The administration and supervision of mental health services and programs is generally carried out by persons from one or another of the mental health professions who have risen to positions of administrative leadership without special training for this work.* At lower levels in the organization the supervisors and unit managers are almost entirely clinicians who carry middle level supervisory and administrative responsibilities *in addition to clinical responsibilities.* At the top level, some mental health programs employ trained administrators rather than clinicians, but these are the exceptions.

Training programs for the clinical mental health professions do not generally provide training in supervision and administration, except on an elective basis for the few students who plan careers in administration. The management skills which are required by most professionals for at least part of their jobs must thus be learned on the job or in short-term continuing education programs after the individual has already been employed in a job that requires such training. Nationwide, there are a few training

programs that offer primary training in mental health or mental retardation administration, but the whole area of administration and supervision needs more attention from the basic professional training programs if there is to be good management and good clinical work.

- *The mental health field has placed more emphasis on the separate professions than any other human service field, except general health. This has been reinforced by the tendency to organize staff by professional departments, and to establish differential payment rates for the various professions. This has led to some difficulties in putting together effective teams and in introducing new kinds and levels of workers. Much more work needs to be done to develop patterns of team collaboration in mental health similar to that in the fields of mental retardation, alcoholism and drug abuse where there is presently more collegiality and less interprofessional conflict.*

OVERALL MENTAL HEALTH AND HUMAN SERVICE TRENDS

Overall the mental health and mental retardation fields are experiencing trends to deinstitutionalization, to community-based services, to stronger attention to client/consumer rights and self determination, to the uses of new levels and kinds of workers, to the development of career systems, to the titling of jobs by function rather than by profession or occupation, and to a stress on competence rather than on academic degrees. All of these trends have been relatively less marked in the acute in-patient psychiatric treatment programs of mental health and much more advanced in those parts of the system that work with psychosocial problems and long-term disability.

These trends and patterns are the backdrop against which a rational scheme for the design of an effective integration of the mental health/human service manpower system must be developed.

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Chapter 3

ISSUES IN INTERPROFESSIONAL RELATIONS

The training for each of the four core mental health professions is relatively independent. A characteristic of any profession is that its practitioners are prepared to assume independent responsibility for certain competencies. At one time, each of the mental health professions was focused on competencies unique to that profession (e.g., psychological testing, nursing procedures of medication giving and physical care, taking social histories and providing social support); but today each profession has moved into assuming a more comprehensive therapeutic role. Yet the role model that tends to be set forth as the ideal for each of the professions is that of the one-to-one practitioner in which that profession plays the major therapeutic role. In this model the other professions are likely to be seen as ancillary. While there is need for interdisciplinary and multidisciplinary functioning, there is relatively little teaching for the practice of truly interdisciplinary service delivery. Only a few of the professional schools and paraprofessional training programs have the linkage to schools of other professions which will enable students to conceptualize a number of interdisciplinary role models.

In organized delivery systems, the situation is considerably improved as a result of the individual professions being brought together in daily working relationships. However, there is still a good bit of dissonance which varies according to the values, procedures and organizational features of each setting. One hears frequent references to the

turf battles that take place among the professions, and how these interfere with the services delivered to clients and raise the cost of the services.

Virtually all organized care systems, except independent practice, claim to use the "team approach," but there are many variations on what is meant by the "team." In addition, it is remarkable how often organizations reorganize and change their concept of the team to suit the orientation of a new leader. There seems to be little overall orientation regarding which models of teams are most appropriate for which kinds of situations.

TEAM MODELS

Among the various models of teams that have been described for mental health and mental retardation delivery systems are the following:

- *The medical team*--In this model a psychiatrist or another physician is the captain and directs the activities of all of the other team members and of the patient. This is the traditional model of the mental hospitals and psychiatric units of general hospitals. It is the model traditionally taught to physicians and nurses, and is expected by medical payment plans. It is an appropriate team model for the acute in-patient care of the mentally ill, but it is less appropriate for other settings.
- *The diagnostic team*--In this model each of the professions does its unique assessment of the patient or client and then all of the findings are brought together at a session during which the diagnosis is decided and a treatment plan is established. This model usually includes inputs from other professions in addition to the four core professions, and often includes a vocational evaluation, an educational assessment, and a variety of laboratory studies or other special studies. As sometimes practiced, the diagnostic team may be inefficient because full batteries of tests and assessment

studies are carried out for all patients/clients when only a few of these tests are actually needed to establish a diagnosis and treatment plan.

- *The co-equal team model*--This model establishes each profession as the equal of each other, with each having an equal vote to establish the treatment plan for the client. Sometimes the professions are said to be interchangeable, but in practice this has limitations. This pattern may lead to a program in which each profession identifies a segment of service it will deliver to clients, even though that profession's expertise may be only marginally needed by some clients. In a variation of the co-equal team, the overall team is assigned to a small group of patients/clients who then make their own choices of which one of the team members they wish to have provide them with any or all specific services.
- *The rehabilitation team*--This is the model sometimes used after the acute treatment phase is over. In this model the various activities therapies (occupational therapy, industrial therapy, special education, social work, etc.) are directed by a rehabilitation worker (counselor or instructor) who sets the plan and assigns the tasks. At times the leader may be from one of the other rehabilitation professions.
- *One-worker coordinated team (case manager)*--In this model one worker is responsible for coordinating all of the information and services on behalf of a client. This one worker may be one of the established professions, or he or she may be a para-professional. This is sometimes called the *case manager* model, but this terminology has a disadvantage if it is assumed that only the records and data for the client must be coordinated rather than the clinical work as well. In this model the worker acts as the client's agent to personally deliver as much of the service as possible and to call for consultation or make referrals only when needed. This model should serve to limit referrals to only those specialists who are actually needed rather than referring the client to an unnecessarily large number of specialists for services that may be only marginally helpful.

In any interdisciplinary team arrangement, the client's interests, feelings and consent should be sought out and given special attention. A *one-worker coordinated team* would seem to be an ideal mechanism for representing the client's interests, since each client will have a case manager who will assume primary responsibility for being the patient/client's agent and advocate. This person will be the major person to whom the

client can relate and trust to keep the whole treatment process integrated for him or her. Such a team model would appear to be the ideal arrangement for incorporating the expertise of the individual professions while also extending the delivery of services to more clients in the highly personalized way that is so critical to success in human service work.

THE "UNIQUENESS" OF THE PROFESSIONS

Each of the professions has come into existence because it had some unique expertise that was needed. Over the years the training and licensing programs for the professions have attempted to stress the unique characteristics and reserve them for the individual professions. Thus, medicine and psychiatry have stressed the diagnosing of illness and the prescribing of medication; nursing has stressed the administration of medications and supportive care; psychology has featured the administration and scoring of tests and research; and social work has emphasized working with families around the social needs of clients and making arrangements for the clients' return to home. Pastoral counseling has stressed the spiritual counseling of clients; vocational counseling has focused on the occupational training and vocational adjustment of clients; and special education has highlighted the special training of clients for both academic and social adjustment skills.

What has often been overlooked is that, while each profession has some area of special expertise, each also has many competencies in common with other professions. Each profession depends on much the same knowledge of human growth and development and psychological and sociological theories and principles. Each profession uses the same skills of interviewing, counseling, modifying behavior, modifying

family dynamics, working through group processes, etc. These common areas of knowledge and skills make up a large percentage of the activity of the professions. Indeed, as the mental health movement has expanded from the mental hospitals to the community, the roles of the individual professions have merged even more. A host of new interventive techniques and new roles have been added for all of the professions. Reality therapy, transactional analysis, family therapy, consultation and education, primary prevention, and mental health promotion are all new techniques or modes of intervention that are shared equally by all of the professions; they are the common property of all. All of this has led to considerable "blurring of roles" of the professions. In actuality it seems more appropriate to see it as a move to feature the common competencies rather than to stress and reinforce the uniquenesses of each of the professions. A University Research Corporation study found that psychologists, social workers and paraprofessionals in community mental health centers reported that they performed virtually the full range of functions related to treatment.¹

In many ways, this appears to be an advantage for the patients/clients. Until recently a newly admitted patient in a mental institution found himself/herself confronted by 14 or more specialists (including the psychiatrist, psychologist, nurse, psychiatric aide, social worker, rehabilitation counselor, various lab technicians, the dentist, the chaplain, the recreation therapist, etc). Each focused on a unique technology, but no one person was charged with the patient's overall course of concerns. In most cases, a person who is already mentally ill or mentally retarded is the least able to put all of these professional

pieces together. The client needs an advocate who can represent his/her interests and plead his/her care with this array of specialists.

At the same time, the delivery system requires an organization that enables the unique expertise of any individual profession to be brought into play *when it is needed*. In many instances this expertise can be provided by consultation, but sometimes it requires that the patient/client be seen by a specialist. In the traditional pattern the client is referred to each successive specialist, thus requiring the client to establish a new relationship with each new specialist who then carries out his interventions and hopes that the client will integrate it all. This is likely to be especially difficult if the individual professionals are operating from different philosophies regarding the nature of the disorder and are using terminology unique to their individual professions and technologies.

Each profession is based on its own set of philosophical assumptions about the nature of mental disorder, its own set of technologies for interviewing, its own terminology and its own concept of the role of that profession in the clinical process. Some of the major issues are:

1. *Differences in philosophies regarding the nature of mental disorder*--There are several different philosophies about the nature of the various emotional and mental disorders and how they are best managed. Each of these philosophies has some validity for certain parts of the total population of mentally disordered persons. Thus, each of these perspectives is needed at certain times.

A medical philosophy. This model assumes that mental disorder has an organic basis, or, at least, that it responds to medical interventions, such as medication and physical procedures. This philosophy is clearly correct for certain major mental illnesses.

A psychological philosophy. This model assumes that there are intrapsychic and interpersonal conflicts which affect the individual's behavior. The interventions are then related to psychological processes to give the individual insight into his behavior and modify his behavior. Clearly this model is also often correct for psychoneurotic conditions and for several other conditions.

A social living philosophy. This model presumes that the problems lie in the interpersonal and social relationships of the family and close associates. This philosophy leads to interventions that modify family and other close transactional relationships to allow all parties, including the client, to function more effectively. This is a relevant philosophy for use in child guidance and in work with the situational disorders.

An educational-rehabilitation philosophy. This philosophy presumes that emotional problems are the result of faulty learning of interpersonal and social skills, and that the remedies lie in educational and rehabilitation techniques to help the clients relearn more effective interpersonal, social and vocational skills. This philosophy is clearly relevant for chronically disabled clients, especially the social and vocational rehabilitation of the chronically mentally ill and mentally retarded, but also for various personality disorders.

A social problem philosophy. This model claims that mental disorder is the result of malfunctions and pressures created by the broader society, rather than a pathological condition within or between individuals. The remedies then lie in social action to change the laws, regulations and functions of the broader society so that the stresses of poverty, racism, unemployment, etc., will be relieved and individuals will be able to function more effectively. This philosophy is the basis for much preventive work.

2. *Differences in techniques of assessment and intervention--*
From the different philosophical concepts about the nature of mental disorder which are held by the different professions, it is clear that there will be different techniques of assessment and intervention that will be chosen to remedy the disorders:

A medical philosophy uses laboratory studies, medications and physical therapies, such as electroconvulsive therapy and biofeedback.

A psychological philosophy uses such techniques as psychological tests, individual psychotherapy, individual counseling, behavior modification and hypnosis.

A social living philosophy assesses family and social functioning and uses case work, group work, transactional analysis, and family therapy with families and significant other persons in the client's immediate social environment.

An educational-rehabilitation philosophy uses special education, social retraining, vocational counseling and instruction, etc.

A social problem philosophy is not used with clients except to organize them into advocacy groups, but instead, uses confrontation, consultation, legal advocacy, etc., in attempting to change the laws and practices and to redirect the resources of the larger society.

3. *Differences in terminology*--Each of these philosophies has its own language and set of terms which are then used by the professions that espouse each individual philosophy. Thus the medical philosophy and the related professions of psychiatry and psychiatric nursing serve "patients" who are "diagnosed" and "treated" in "hospitals" or "clinics," while exponents of other philosophies are likely to "counsel," "casework" or "teach" "clients" or "learners" in "centers," "shops" or "classrooms."

None of these philosophies is held exclusively by any one profession, but each philosophy tends to provide the center of gravity for one or another of the different professions and their interventions. These differences in philosophy, technology and terminology provide the basis for some of the rivalries and turf guarding among the professions, but they also provide the mechanisms for meeting the needs of a range of clients with diverse mental disorders. It is important to realize that all of these philosophies and professions are useful at some time or another. A well-designed personnel/manpower system will enable

calling into play when needed the appropriate expertise with a minimum of delays and also with a minimum of unnecessary referrals for studies and therapeutic trials that may be only marginally indicated or desired for individual clients.

The case manager concept promises to relieve some of this problem, since the worker will ordinarily seek consultation from the specialist about the problem before the client is referred to a specialist. If the worker obtains sufficient direction and support, he or she will proceed to carry out the appropriate interventions directly with the client, thus obviating the need for separate referral. If it is agreed in the consultation that the client needs to be seen by the specialist, then the worker (case manager) will arrange the referral and continue to represent the client's interests and concerns in relation to the various specialists and their technologies. Such a team will often collectively see the patient/client for initial assessment and overall treatment planning if the client is in a setting (e.g., an in-patient service) where it is convenient to do so before the case is turned over to the worker (case manager) who will carry through on the plan. It is to be expected that there will be instances in community mental health work in which it will not be feasible to assemble the full team, but the full team will nevertheless continue to exist and be available as needed.

MANAGEMENT AND SUPERVISION

In addition to these team considerations, there are other major functions for the professions in organized delivery systems. In a significant way the established professions have important responsibilities

in administering the various services and supervising the workers who will carry out much of the direct clinical work with clients. Studies have shown that 40 percent of professional workers in organized mental health care systems have some administrative or supervisory responsibilities in addition to their clinical duties.² In this instance, "administration" does not refer to the overall administration of the entire mental health center, but only to the management of some unit such as a satellite unit, a consultation and education unit, a children's unit, or supervision of a few workers within the overall program. It is virtually impossible to conceive that the mental health delivery system could ever realistically expect to employ trained administrators and supervisors for all of the many middle management positions which require both clinical and managerial expertise. Mental health professionals must be trained for such supervisory and managerial skills as well as for direct clinical practice if they are to work in organized delivery systems.

TEACHING AND EVALUATION

In addition to these middle management and supervisory functions, many professionals in organized care systems find that a considerable part of their duties includes functioning as instructors in staff development programs and in public education programs and in evaluating the services for which they have programmatic responsibility. Their performance in these areas is sometimes weak because their professional training has not prepared them for other than direct clinical roles. This also should be changed so that professionals will be better prepared for roles as teachers and as program evaluators in organized

delivery systems. In a few cases the professionals will conduct research studies--either evaluative or experimental research--which will require considerable expertise in research design and statistics. For most professionals this will probably be a step beyond basic education.

ORGANIZATIONAL ISSUES

These notions of various models of interdisciplinary teams and expanded organizational functions for the professions argue for some clearer notions of how to best organize and deploy the professionals in organized mental health delivery systems.

OTHER FACTORS IN INTER-PROFESSIONAL RELATIONSHIPS

There are other factors that have reinforced the rivalries between the professions that are extrinsic to the needs of clients and the specific competencies of the professions. These include such matters as status differences between the professions, licensure restrictions, organizational patterns, differential salary and reimbursement schedules, agency policies and practices (i.e., some agencies employ only certain professions or use only certain technologies), and supply and demand (i.e., some agencies during the expansion period of the late 1960s employed new professionals because they were unable to recruit the core professionals). All of these factors are important issues for the mental health administrator to consider in managing the agency's personnel, although they are not primarily related to the needs of clients or to the nature of the work to be done.

RELATIONSHIPS BETWEEN THE PROFESSIONS AND THE PARAPROFESSIONALS

The new levels of workers that collectively comprise the paraprofessional movement have grown up largely in response to local needs and local initiatives rather than as a result of any concerted activity on the part of the professions. Individuals from the professions have been among the leaders of the paraprofessional movement, but there has been relatively little action to integrate the roles of paraprofessional workers with those of the established professions. Thus most professionals and agency administrators have only sketchy awareness of the possible roles and functions of paraprofessional workers and their utilization in an overall manpower system for the delivery of services to clients.

PARAPROFESSIONALS PRODUCED BY JOB FACTORING

Perhaps the most natural approach for a professional person to assume when planning to train and use new levels of workers is the *job factoring* approach. In job factoring the tasks of the overall job of professionals are factored out; and then certain of these tasks are assigned to new levels of workers. These tasks are likely to be those which are more routine and choresome, and the new jobs produced by job factoring are very likely to be conceived as "aides" or "assistants" to the professionals. Very often the jobs are given such titles as Social Work Case Aide, Nurse Aide, Psychological Assistant. The job descriptions then call for the worker to perform under the direct close supervision of the professionals and to exercise very little independence of judgment or action. The jobs are often

dead-end jobs with little chance for advancement unless the workers go back to college and complete the standard course of study for the profession.

Many jobs in the paraprofessional system have been developed and implemented in just this way, and some of the training programs in the community colleges and technical institutes reflect this job factoring approach. Often professionals in agencies assume that any paraprofessional worker should function in this aide or assistant role. However, there are many other possible models for the use of paraprofessional workers.

OTHER POSSIBLE PARAPROFESSIONAL MODELS

Individuals in a few of the professions have analyzed the possible roles and functions of paraprofessionals in greater depth than that implied in job factoring and have concluded that there are other roles that paraprofessionals might play in addition to being just aides who work under the direct supervision of the professionals. From this two major new roles have emerged:

Outreach worker--Some professionals realized that they themselves were limited in what they could do with clients in the office or clinic setting, but that the paraprofessionals might go out to families in the community to reinforce the work being carried out in the clinic. Thus paraprofessionals were trained to do educational and consultation work with families and others to reinforce the speech therapy, behavioral therapy, social retraining, etc. that was being undertaken in the clinic. The paraprofessional workers used their own initiative and judgment in this outreach work, but always were under the general supervision of the full professional.

Intake and eligibility workers--In some agencies it was necessary for the professionals to spend considerable time in intake work to establish the eligibility of the client for services.

This was especially likely to be the case when the client might receive some cash benefits, but there were several other eligibility requirements, such as age, residence, citizenship, referral source, kind of disability, etc., that applied to other human services. Thus, in some settings, paraprofessionals were trained and employed to do intake work and eligibility determinations only. These workers also functioned under the general supervision of the related professional.

In general, these three patterns--the aide, the outreach worker and the intake worker--have been the models of paraprofessionals that have been incorporated within the established professions.

GENERIC MENTAL HEALTH/HUMAN SERVICE PARAPROFESSIONALS

Meanwhile, in other parts of the mental health and human services manpower system, namely at the level of the operating agencies, another paraprofessional manpower development was under way. Agency administrators looked at the total job to be done for clients and communities and concluded that there were many aspects of the work that did not fall neatly under the responsibilities of any of the established professions.

They used another approach, which is known as the *developmental approach* to new job formulation. The developmental approach recognizes that the professions have come into existence to meet specific needs of clients, but that as they develop and grow, the focus is on those aspects of the total job that are most prestigious and convenient for the professionals. Other aspects of the needs of clients that are more onerous and inconvenient are discarded. Thus, in formulating new jobs to meet an agency's overall mission, it is necessary to examine the full range of needs of the clients and then decide what must be done to meet *all* of those needs with the most appropriate constellation of job assignments.

With the use of the developmental approach by the Southern Regional Education Board and other agencies, certain needs of mental health clients were identified that were not generally being met by any of the established professions.³ Among these unmet needs were the needs for advocacy, aftercare, and outreach to help persons with emotional problems realize the nature of their problem and to help clients make contacts for services from whatever agencies could provide the services they required. These were in addition to the traditional needs for diagnosis, therapy, behavior change, education and physical care, etc. which were generally being met by one or another of the established mental health professions.

When the needs of the *agencies* themselves were examined, it became apparent that there are also data gathering and reporting needs (both for individual cases and overall programs), educational and consultation needs and a range of administrative and supervisory needs which must be carried out by workers in order to meet the overall mission of the agency.

For each of these major areas of need (of clients, communities or the agency itself) there was judged to be a corresponding "role" that some worker needed to carry out. By "role" was meant a set of *alternative activities and functions all intended to achieve a common objective (i.e., to meet one of the major identified needs)*. The major roles were:

1. *Outreach (human link) worker*--Reaches out to detect people with problems, to refer them to appropriate services and to follow them up to make sure they continue to their maximum rehabilitation. Until recently this role rarely had been played in most mental health programs.

2. *Broker*--Helps people get to the existing services and helps the services relate more easily to clients.
3. *Advocate*--Pleads and fights for services, policies, rules, regulations, and laws for clients. This role also has rarely been played in mental health agencies.
4. *Evaluator*--Assesses client or community needs and problems whether medical, psychiatric, social, educational, etc. This includes formulating plans and explaining them to all concerned.
5. *Teacher-Educator*--Performs a range of instructional activities from simple coaching and forming to teaching highly technical content directed to individuals or groups.
6. *Behavior changer*--Carries out a range of activities planned primarily to change behavior, ranging from coaching and counseling to casework, psychotherapy, and behavior therapy.
7. *Mobilizer*--Helps to get new resources for clients and communities.
8. *Consultant*--Works with other professions and agencies regarding their handling of problems, needs and programs.
9. *Community planner*--Works with community boards, committees, etc. to assure that community developments enhance positive mental health and self and social actualization, or at least minimize emotional stress and strains on people.
10. *Care giver*--Provides services for persons who need ongoing support of some kind (i.e., financial assistance, day care, social support, 24-hour care).
11. *Data manager*--Performs all aspects of data handling, gathering, tabulating, analyzing, synthesizing, program evaluation and planning. (This may be simple case data or highly sophisticated program data).
12. *Administrator*--Carries out activities that are primarily agency or institution-oriented rather than client or community-oriented (budgeting, purchasing, personnel activities, etc.).

CLUSTERING OF WORK INTO JOBS

Those who used the developmental approach then had to decide how to best cluster these roles into jobs for individual workers--both

the established professionals and the new paraprofessional workers.

There are several alternative ways in which work to be done might be assigned to make up jobs for individual workers. These are:

- *Around specific tasks or activities*--The worker's job consists of carrying out a single task or a small set of tasks or activities. Examples from mental health/human service work are psychometrists who do only psychological testing, and eligibility workers who carry out only the task of determining eligibility for services.
- *Around major program functions*--The worker's job consists of a much wider spectrum of activities, but is still limited to only a major portion of the client's overall need. Examples are outreach workers, rehabilitation workers, and aftercare workers.
- *Around specific professions to function as aides or assistants to the professions*--Examples are social work case aides, recreation aides, occupational therapy aides and psychological assistants.
- *Around the logistical needs of the agency at a particular time and place*--The activities of the job are grouped together because the agency needs them to be done at a certain time or place. Examples are the night supervisors of hospitals who carry out patient care duties, supervise psychiatric aides, perform drug room activities, answer telephone inquiries, etc., and satellite mental health directors who do whatever needs to be done in a specific satellite location.
- *Around the needs of a small group of clients and their families*--In this case the worker functions as an aide to his or her group of clients to carry out whatever roles are required to help the clients restore themselves to as independent social living as their capability allows.

These workers function as advocates on behalf of their clients, carrying out whatever functions are needed themselves while seeking consultation support and referring their clients to full professionals for specialized services as needed. Even then the workers continue their relationships to the clients and the specialists much as family physicians continue to carry responsibility and concern for patients whom they have referred to specialists.

This has been called the "generalist" model because the workers must be prepared to play any roles needed by their clients at some basic level of adequacy. It does *not* imply that the

workers have high level of expertise in every possible task or activity, but rather that they must have basic competence to meet their clients' needs across the board.

Actually, each of these foci has been used for formulation of certain jobs, and realistically it is likely that there will always be the need to formulate certain jobs according to any one of these criteria. However, it is also essential to examine the implications of each of these job formulations for clients and for the overall mission of the agency.

The focus of jobs according to specific tasks or agency logistics is likely to concentrate on the needs and procedures of the agency, since they are formulated primarily to meet the agency's administrative needs. Formulating jobs as aides to the professional's is likely to produce jobs that are sensitive primarily to the professions rather than to the agency or to the clients. Formulation of jobs according to major program objectives orients the workers to program issues (e.g., treatment, rehabilitation); focusing jobs according to target groups of clients is likely to produce workers who are sensitive primarily to individual client needs across the board. Since the major mission of a human service program is to meet client needs, it would appear desirable whenever possible to focus the jobs of workers according to the needs of small groups of target clients.

There is the added fact that the success of mental health and human service work requires the active understanding and participation by the clients for a favorable outcome to occur. It appears even more likely that the most advantageous job orientation is the generalist worker whose job is focused on a small group of clients

and their families throughout the entire course of intake, assessment, treatment, rehabilitation and aftercare. Such a job orientation of an individual worker will help the clients better understand the total clinical process and be motivated to do their part in the treatment and rehabilitation program and restoration to the community.

The mental health/human service generalist focus has become the preferred orientation for many paraprofessional workers and training programs. The jobs are titled something like "Mental Health Worker," "Mental Health Technician," "Mental Health Associate," or "Community Mental Health Worker," and the training programs are given titles such as "Mental Health Technology," or "Mental Health Worker." The jobs and the training programs are designed and titled to serve the broad problem field of Mental Health rather than just the traditional professions. The training programs and the job descriptions are based on that body of knowledge and skills that are common to all of the professions rather than on the unique skills of any single profession, and the job functions cut across the traditional professions. Where this pattern has not been clearly articulated and made clear to all staff, there have sometimes been conflicts with the established professions who have felt that these new workers were practicing in their professions.

HUMAN SERVICE PARAPROFESSIONALS

This trend to establish paraprofessional jobs and training programs oriented to the overall program field rather than to the traditional professions also has been going on in other human service fields.

The term Human Services has several possible meanings and connotations. In the broadest sense it includes all of the programs, professions and agencies that help people function better in any bio-psycho-social area or to detect and remedy malfunctions in any of these areas. In this sense it includes all of the health, social welfare and rehabilitation professions.

In another sense the term Human Services has an organizational meaning (i.e., the Department of Health, Education, and Welfare, state departments of Human Resources, or some similar title).

In still another sense, the term Human Services may be used to apply to an occupational or professional group (e.g., Human Service Workers). At this time, several of the program fields within the human services have created job titles and training programs oriented to an overall field rather than to a specific profession (e.g., Aging Program Workers, Child Care Workers, Corrections Officers, Alcohol and Drug Abuse Counselors, Mental Retardation Program Workers, Community Service Workers). This is especially true of training programs and jobs at the entry and technical levels, but there is a trend toward the establishment of generic training programs of this kind at baccalaureate and master's degree levels and for related job series and career systems to be established in the agencies. In several places the training programs and the workers themselves have chosen the title "Human Service" rather than a specific program field since they have found they have greater job mobility with the more generic title.

Thus, in addition to the two dozen or so community colleges that now have Human Service Worker training programs, at least two of the organizations of workers use this terminology (i.e., the National Association of Human Service Technologists and the National Organization of Human Services). Much of this use of the term Human Services has grown from those who began in the field of mental health, but found that many jobs were available in juvenile courts, school counseling services, nursing homes, and a range of other human service programs that were not identified as specialized mental health service programs so that it seemed appropriate to broaden both the title of the training program and the content of the program itself. Another major group of paraprofessional workers who use the terminology "Human Services" are those who concentrate on the field of community development/advocacy.

Thus what has emerged is a trend, at least at the occupational levels, to train and title workers according to either a specific program field or the overall Human Services field rather than according to the traditional professions. The emerging picture might be diagrammed like this:

The word "paraprofessional" has several possible meanings. One meaning is a worker closely related to a profession, but another possible meaning is a worker who assists a professional. According to these definitions both those workers whose jobs and training programs are closely related to the professions and those workers whose jobs and training programs are oriented to broad human service program fields can be called paraprofessionals. However, it is *essential to recognize that there are two separate philosophical streams of workers involved*, each of which has a validity of its own. More essential is to understand the relationships of these two paraprofessional trends to each other and to the existing professions, both in career systems in agencies and in the academic training system for the occupations and professions.

Within the paraprofessional system based on professions the workers are assigned to specific professionals or professional departments and work under their direct supervision. They may be in aides or assistants or outreach or intake roles, but always in close association with the related profession. These persons generally exercise little independence of judgment or action, especially in any activity that lies outside of the prescribed borders of the profession. However, they may develop considerable expertise in certain specific technologies of that profession.

Within the paraprofessional system based on program fields the workers have been employed in a variety of functional positions that reflect the generalist concept in which most are trained. Among them are:

1. *Direct care staff in children's services, geriatric services, mental retardation services and day hospitals* in which the workers are assigned to a small number of client/patients to carry out the direct care and treatment as part of a team in which the overall treatment plan has been agreed upon by the full team.^{4, 5, 6, 7, 8, 9}
2. *Alcohol and drug abuse counselors*--These are often chosen from among persons who have had a personal experience with alcoholism or drug abuse so that they have a unique rapport with such clients. However, they carry a case manager kind of responsibility for the specific clients they serve.^{10, 11}
3. *Community aftercare workers*--These workers in transitional services help their clients with all aspects of their community placement and adjustment. This includes working with the clients in counseling and teaching activities as well as arranging for outside community resources for clients.
4. *Day care and social rehabilitation workers*--These workers have a close relationship to help a group of clients with their community adjustment in such settings as day activity programs, social rehabilitation programs, halfway houses and other transitional service programs.¹²
5. *Board and home care operators and staff*--Many former mental patients and mentally retarded persons have been placed in group homes, sometimes called board and care homes, which are staffed by workers with a broad set of responsibilities for their residents. Some nursing homes employ mental health workers to work with former mental patients placed in their nursing home.
6. *Outreach workers in community programs* where the workers seek out emotionally disordered persons and either provide services directly or help them obtain more specialized services.

Many generic paraprofessional mental health workers function in a wide range of positions that do not reflect the full generalist concept. These include work in consultation and education programs, crisis centers and hot line programs, community and neighborhood organization, and gathering of information for program planning and evaluation. The jobs of paraprofessionals are structured in many different models according to local needs. Some carry out single tasks or functions, such as

eligibility determinations or intake work; some are limited to institutional roles, or to roles as teachers or consultants.

The jobs of generic paraprofessional workers may not include activities from *all* of the individual roles, but the jobs generally combine activities from a large number of roles. One role--advocacy--is often excluded from the generic worker's job because many agencies do not conceive advocacy to be a proper function of an agency. However, in an increasing number of mental health agencies there are workers, called ombudsmen or patient advocates, whose jobs depend heavily on the use of advocacy skills. Mental health and human service paraprofessional workers have often been employed in these ombudsmen or client advocacy roles.

In actual practice there are many variations in the ways in which paraprofessional workers are trained and articulated with the professionals in the delivery system, just as there are wide variations in the roles and relationships between the professions. Some variations are undoubtedly needed depending on the specific needs of individual programs and settings. However, much of the present variation is the result of rather randomly chosen arrangements for which there is little thoughtful rationale. Arrangements are selected because they are traditional, or because the Merit System requires it, or because of the influence of a single individual in the system, or just because it seems to make sense. This is not surprising since there has been very little conceptualization of a comprehensive manpower schema for the utilization and training of the full range of professions and paraprofessionals which could be used by mental

health/human service administrators and manpower development leaders. Much work is needed to research and refine the issues that will provide guidelines for the most effective ways to articulate the various workers with each other to assure that the expertise of the professionals is delivered to the patients/clients in the most effective ways.

EXISTING PATTERNS OF PROFESSIONAL-PARAPROFESSIONAL UTILIZATION

At present there are identifiable patterns of paraprofessional-professional utilization that are likely to be observed in certain kinds of mental health settings. Whether these patterns will bear up under scrutiny of their overall effectiveness and efficiency only specific studies will tell. Among the present patterns are these:

- Hospital programs for the acute care of the mentally ill tend to use the medical model and make primary use of fully qualified professionals of the traditional kinds. Paraprofessionals tend to be present in custodial roles or as aides to one or another of the professions.
- Specialized treatment units, such as children's, geriatric, mental retardation, and alcohol and drug abuse units are more likely to use paraprofessionals in generic models along with professionals. The overall treatment plan is decided upon by the full team, but the execution is likely to be assigned to individual members, including paraprofessionals.
- Mental health programs in cities and prosperous suburbs are more likely to use primarily professional workers and a sprinkling of paraprofessionals who function as aides to professionals. This is not true, however, of community mental health programs in poverty or ghetto areas of the cities. In poverty areas of the cities there are likely to be paraprofessionals with generalist functions, especially in satellite programs of the mental health centers.¹³
- Mental health programs in rural areas are likely to make considerable use of paraprofessionals who, along with the professionals, function in generic roles. The relative shortage of staff persons requires everyone to be more generalized, and the workers relate to each other in more personal ways.¹⁴

- Mental health programs with a social-rehabilitation orientation make greater use of paraprofessionals than those with a heavy medical and psychiatric orientation. These programs are also more likely to work with chronically ill clients or with mentally retarded persons than with the acutely ill. The job orientation of the paraprofessionals in such long-term care programs is more likely to be that of the generalist.
- Programs that work with clients in their own homes, foster homes, group homes, and neighborhood settings make extensive use of paraprofessionals of the generalist orientation. Professionals frequently are not available to do this home visiting and neighborhood travel which are both time-consuming and expensive.
- Large bureaucratic agencies tend to use professionals and paraprofessionals in the professional aide model while smaller and more innovative agencies frequently use functional job titles and organizational forms. Thus, smaller community-based agencies seem to be able to use both professionals and paraprofessionals in more flexible ways.¹⁵

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Chapter 4

CAREER SYSTEMS AND LEVELS OF WORKERS IN MENTAL HEALTH AND MENTAL RETARDATION

The mental health and mental retardation manpower systems have been essentially devoid of any career systems. Even within the professions there have been only meager career systems consisting of a small number of pay steps in an agency's personnel system with the progression based essentially on length of employment and the number of employees one supervises. A few agencies have experimented with programs to allow professionals to advance on the basis of advanced clinical practice instead of on the basis of supervisory and administrative activities, but such career systems have been very limited. The typical pattern of career advancement requires the worker to move into administrative responsibilities. This is particularly noticeable among male professionals in social work, psychology and counseling who, recognizing that this is the way to achieve career advancement, seek out administrative positions relatively early in their careers. Men who have family obligations have especially strong career aspirations.

It is generally recognized that career advancement solely through years of service in a single agency is a slow process, and many mental health professionals make frequent job shifts from one agency to another in order to move up in their careers more rapidly. A remarkable number of mental health professionals have made their careers by this kind of spiral through several human service agencies (e.g., mental health, welfare, youth services, corrections), perhaps returning to mental

health programs from time to time as they climbed to higher administration levels of both job responsibilities and salaries. In a very real sense these persons are human service professionals. There are advantages to the mental health system and to the broader human services system in having professionals with a broad base of experience in several agencies, but this pattern has not been the result of a career system developed by manpower planners.

LEVELS OF TRAINING IN ACADEMIA

Within the academic institutions that prepare persons for the professions, there have been several attempts to distinguish various levels of workers. At first these efforts were largely oriented to preparing workers at *advanced* academic levels beyond that ordinarily considered to be the basic professional level. These advanced degree programs generally concentrated in one of four areas of specialization:

Advanced clinical practice--This was often training in highly specialized skills of intervention.

Research skills--This was usually training for academic research careers.

Teaching skills--This specialization was particularly oriented to preparing faculty persons for professional schools.

Administration--This specialty training was usually oriented to preparing persons who were interested in becoming top level administrators in mental health or human service agencies.

Within the agencies there is relatively little recognition for such advanced degrees or postgraduate training so that many of these persons find employment on the faculties of academic institutions where there are special rewards for higher academic training. In

service delivery agencies the fact that a person has an advanced degree or postgraduate work may favor his being employed in top level positions, but agencies seldom make the possession of such advanced training a requirement for employment or provide higher salary levels because the person obtains such a degree.

More recently, under the pressures to expand the numbers of human service manpower in the 1960s, academic programs to prepare practitioners have been undertaken at academic levels immediately under those of the basic professional level. At first these programs were almost uniformly conceived as professional aide training programs or as narrowly specialized technician training programs. The basic objectives were to train new levels of workers who would work only under the direct, close supervision of professionals or who would function within the confines of a narrowly prescribed technology (e.g., psychometrics). However, it soon became apparent that these approaches would not be sufficient to meet the needs for increasing numbers of workers, and so a trend developed to conceptualize these academic programs as alternate entry levels for professional workers--especially for direct client work with relatively uncomplicated cases. This posed some degree of confusion because individuals were entering professional practice from two or more academic levels. Employers and the general public have sometimes found the distinctions unclear.

The professions have been slow to conceive career systems that include a full range of workers--from entry level, for persons coming into employment with no previous training for the profession, and extending through several levels to include highly specialized persons

with postgraduate training. The professions generally tie whatever levels exist within the profession to an academic degree in a professional or occupational education program. Thus, there is likely to be no recognition by the professions of workers who have been trained in in-service training programs or in technical institutes, although such workers make up a considerable segment of the employees of most mental health and human service agencies.

LEVELS OF WORKERS IN AGENCY PROGRAMS

Little thought has been given to a rational system of levels of workers within the agency career systems. While a considerable number of entry and technical level workers have been employed by the agencies at times when full professionals were not available or were not required, the assignment of these workers has varied according to local needs and decisions. A few state level mental health agencies have developed career systems in their personnel classification systems, but few of these plans have actually become operational for more than a handful of individual workers. In most states the career ladders for mental health workers consist of only a few steps; but in some states (Maryland, New York, and Illinois) the career systems on paper have been quite extensive so that workers could progress through several career steps if they continued to increase their competence.¹ The increased technical competence is usually gained through further education (either short-term continuing education or advanced formal course work), but it may also be gained from work experience. Despite the pattern of promoting persons on the basis of competence, agencies still have a tendency to require

a specific academic degree or some equivalent training and work experience for original employment; this is especially true for professional level workers.

GENERAL LEVELS OF WORKERS

There is no universal acceptance of levels of mental health/human services workers or the criteria for any such levels. The old artisans' guild system specified three levels:

Apprentice--Persons who had come into the field to learn the trade.

Journeyman--Persons who had attained sufficient competence at the trade to be considered to be basically adequate practitioners of the trade.

Master--Persons who had attained superior competence and were the truly creative artists and teachers.

In the days of the artisan guilds there were no separate academic training programs as there are today for the mental health/human services occupations and professions, and so this scheme of levels included the training system as well as the practice system. Nor were there agency bureaucracies in which these artisans were employed; they were essentially private entrepreneurs.

While there are no firm manpower schemes for levels of work for the modern human services, society in general is coming to recognize four general levels of workers. There may be several steps within each level, and many persons will choose to define five or more separate levels, but the four that are generally recognized are: entry level, technical level, associate professional level and professional level. These were described in more detail in Chapter 2.

CRITERIA FOR LEVELS OF WORK

The above are very rough guidelines for the development of levels of workers. There has been very little systematic work toward the development of criteria for deciding levels of work to assign to different levels of workers in mental health and human service work. However, industrial psychologists have given considerable attention to levels of work in society's overall employment system. Among the criteria that are described are some which are intrinsic to the nature of the work to be performed and others that are extrinsic to the work, but depend more on the specific agency setting in which the work is carried out.

Among the criteria that are *intrinsic* to the work to be performed are:

The *complexity* of the problem or work. Simple situations (a single client with a single, simple problem) may be managed by lower level workers. The more complex the problem (e.g., a multi-problem family with several seriously disturbed members), the more likely that a highly qualified professional worker will be needed.

The *difficulty* of the work. Work that requires common skills (e.g., gathering and giving information, advising) may be done by a lower level worker than work that requires skills of great technical difficulty (e.g., statistical analysis, intensive psychotherapy).

The *risk* to the client of a job poorly done. Work that will result in only minor inconveniences if poorly done may be carried out by lower level workers, whereas if the risk is suicide or permanent disability, the job requires a full professional.

The criteria that are *extrinsic* to the work appear to be more related to the setting:

The *availability and accessibility of supervision and consultation*. This factor is described in other ways also (e.g., the length of time between the supervisor's giving of the

instruction and the performance of the work, or the time between the performance of the work and the supervisor's review of it). In any case, work may be carried out by low level workers if supervision is immediately or soon available, but otherwise the work requires a more qualified worker.

The degree of prescription of the work--When the work is very specifically prescribed either by a supervisor or by written policy and procedure statements, it may be performed by a lower level worker. This is also sometimes defined as the degree of independence of judgment and action.

The agency policy regarding the use of various levels of workers--Some agencies require that all staff persons must be fully qualified professionals. This precludes the use of other levels. Public agencies are more likely to employ all levels of workers than are private mental health/human service agencies.

Supply and demand for workers--This item is closely related to agency policy. When market conditions make it difficult to recruit full professionals, public agencies will very likely employ persons with lesser training, as they did in the late 1960s. In times of surpluses of professionals, they will very likely disdain those with lesser experience unless cost is a major consideration.

Logistics of the situation--There are some situations in which certain kinds of work simply must be carried out by certain workers to meet the logistics of a situation. For example, an entry level worker from a minority group might work with an actively suicidal patient from the same minority group because the patient does not trust anyone else. Or, at the other extreme, a high level professional may be called upon by county commissioners to provide routine information because the commissioners do not want to hear it from a clerk.

These are criteria that require considerable judgment in their application to mental health/human service work, unlike certain industrial settings in which work consists almost entirely of activities with *things* (i.e., tools, materials and products) or with *data*, both of which are rather predictable and measurable.² In contrast, mental health/human service work consists almost entirely of work with *people* and data. People are much less

predictable than things, and this may account for the reluctance of mental health manpower systems to consider multiple levels of workers until recently. However, the realization that there cannot be enough fully trained professionals to deliver the needed services to all possible clients, and the realization that it is possible to develop a system that delivers the expertise of the specialists through other levels of workers, has brought about a reconsideration of the former attitude that mental health work could only be done through full professionals.

However, there are certain criteria for assigning work to lower level workers that probably should *not* be used unless there is clear demonstration of their validity to meet the needs of clients. They include:

Routine and boring work--There has sometimes been a tendency to assign paper work and record keeping or other choresome tasks to new levels of workers because these are less challenging duties.

Unpleasant work or less hopeful clients--There has also been a tendency to assign clients with greater disability and perhaps considerable physical care needs (e.g., the aged and organically brain damaged) to persons with lesser training because these clients are less likely to improve and/or have needs for physical care procedures which many professionals find unpleasant. In most respects these are the clients who require the greatest expertise.

Less prestigious work or less convenient hours--Often lower level workers are assigned to duties, such as making home visits, escorting clients to appointments, or working nights and weekends, because these duties and hours are inconvenient and less prestigious. Actually these activities and working hours may be the ones which can provide the greatest therapeutic impact for clients. It may be that these are quite appropriate assignments for new levels of workers, but the importance of the therapeutic relationship must also be recognized.

ASSIGNING WORK TO LEVELS OF WORKERS

From the descriptions of possible job formulations from this chapter and the previous one, it is obvious that there are several options for making up jobs for new levels of workers ranging from those made up from 1) a single task or activity, 2) those designed to relieve the professionals of certain choresome tasks, or 3) jobs that play a much more integral part in the therapeutic and rehabilitative process for clients.

However, persons who plan manpower utilization systems, write job descriptions, establish career ladders, and train and test workers for competence at various levels need some overall guidelines for a scheme of levels that will make the most effective use of all the available manpower. This requires a system that promises to be most effective for clients as well as providing the greatest satisfaction for the workers themselves.

Because of the wide variety of worker and client needs, it appears that several alternative tracks should be available. Many observers have noted that career patterns at both the entry and the top professional levels tend to be more generalized in their orientation, while positions in the middle are more likely to be specialized. This provides a kind of hourglass pattern to the career system for any particular worker. However, there must still be alternatives for individuals who do not fit what seems to be the most desirable *overall* pattern.

Career systems for various levels of workers must be sufficiently *specific* so that the workers have useful competencies for any particular job in which they may be employed and yet allow them to transfer to

other positions or to other agencies without having to go back and enter an entirely new training sequence. There must also be sufficient *generality* at each level so that educational institutions can understand the levels of expectation and competencies that will be expected of their graduates from various academic programs as their graduates go forth to seek employment in a variety of agencies and settings.

These then seem to be some of the guidelines for the four major levels of workers that have already been described:

Entry Level

The entry level is very much the equivalent of the apprentice level in the guild system. These workers who come into the system with no formal training for mental health or human services work are still in the stages of learning and testing of their basic competencies for this kind of work. This is true whether their training is provided through in-service education programs or through affiliation agreements with technical institutes or community colleges.

- From the perspective of the needs of clients for a single worker to whom they can relate, rather than for more fragmentation among workers, it appears desirable that these jobs and training for them be oriented to generic models of service rather than to single tasks or activities. However, in specific job settings, these workers may be asked to learn and assume jobs made up of only specific tasks.
- The clients served by entry level workers should have relatively uncomplicated problems *or* the treatment and rehabilitation plans should be clearly defined and made explicit for these workers.
- Supervision for these workers should be readily available and accessible to the workers. Also the supervisors should keep in close touch with the workers in providing a developmental kind of supervision which focuses on consultation and education for the worker rather than simply monitoring the work for compliance with predetermined standards.

- Entry level workers are most appropriately used in either institutional or fixed facility programs (i.e., day care centers, sheltered workshops) in the community rather than in independent community placements. Their training and supervision can be better carried out in such settings where other staff are readily available to observe and modify any inappropriate patterns.
- Assignments of entry level workers to a group of clients on a ward or service should be of sufficient duration and constancy so that they develop a sense of commitment to their clients and can see improvements occur. Yet there should be sufficient variation in assignments that they learn about a variety of clients and services.

When jobs for entry levels must be made up around specific tasks or in relation to a single profession, it should be recognized that this pattern may lead to dead-end jobs and increased turnover. It may be possible to provide rotation of workers through such assignments so that the workers also have expanded opportunities for career advancement.

Technical Level

These workers should have a sufficient level of competence to provide for the direct care needs of ordinary clients and their families under general supervision. Like other workers they will require orientation programs to learn the specific operating policies and procedures of the specific agencies in which they are employed.

- Technical level workers are expected to serve the direct care needs of clients and families with the everyday problems seen by the agency. They should not assume responsibility for clients with extraordinarily complex or difficult problems unless requested to do so by a supervisor and then only with ready access to supervision. They frequently function in generalist roles.
- Technical level workers ordinarily work under general supervision of more experienced persons. However, they require ready access to supervision in case extraordinary problems

suddenly present themselves. These workers need a strong commitment to team work and an awareness of their possible limitations.

- Technical workers should be able to function in relatively independent community placements in which they help a small group of clients with a range of psychosocial needs, as in aftercare or community education work. In all cases they should be expected to report their activities and problems to some more experienced team member or to the full team that is responsible for the program.
- Technical level workers should be able to manage local group action projects in a neighborhood or in collaboration with a local agency or gain additional resources or open new opportunities for clients. (Local agencies might include a church, a local recreation program or a neighborhood association).
- Technical workers may be expected to carry supervisory responsibilities for a small number of entry level workers in certain situations.
- Technical workers should be expected to develop some special expertise in the techniques and strategies of the sub-field in which they work (e.g., children, alcoholics, the aged, etc.). This may be learned from in-service education programs or from continuing education courses. This special expertise may not be expected at the time of their initial employment, but it should be expected of workers during their employment.

Technical level workers should have attained sufficient competence to function as generalists in the direct care of the everyday clients and families seen by the service or program in which they work. This expertise may be developed through work experience and training as entry level workers, or it may be developed through formal one- or two-year training programs in technical centers or community colleges. These workers should have a reasonably comprehensive knowledge of the broad psychosocial needs of clients and of the strategies to help attain them.

These workers should have a strong commitment to their occupational/professional self-development, but also a sense of their limitations so that they seek out supervisory consultation and educational opportunities to improve their skills. They function under supervision in an organized care system where they receive regular supervision but still exercise considerable independence of action and judgment once the overall plan is set for the patients/clients.

Associate Professional Level

Associate professional level workers carry out the ordinary and some of the extraordinary functions required by their clients and many carry relatively simple managerial functions in relation to sub-units of larger programs or in the management of small programs. They work under general supervision of a larger program with access to fully qualified specialists.

- Associate professional level workers may function as generic workers in the direct care of the ordinary and some more complicated and difficult clients and families. These may be multiproblem clients and families or clients requiring more technical expertise than the average client.
- Associate professional level workers function under general supervision of a larger program, but they require ready access to specialists for consultation and supervision of their work. Their work should be given regular supervision by some fully qualified person.
- Associate professional level workers may have considerable expertise in certain specialized techniques (e.g., behavior modification, family therapy) or in some sub-field (e.g., children, alcoholism, drug abuse) in addition to their generic competence.
- Associate professional level workers should possess the expertise to function in a community or neighborhood group to modify practices and develop resources to better serve their clients and families. This includes competence in education and consultation.

- Associate professional level workers may carry supervisory or middle managerial duties in addition to their clinical assignments. Their roles as consultants and supervisors to entry and technical levels are often substantial. Also, workers at the associate professional level may become managers of sub-units of larger programs (e.g., managers of hot-line, satellite or day care programs or half-way houses).

- Associate professional level workers should have a high level of occupation/professional commitment and an interest in improving themselves and the services in which they work by careful data gathering and analysis for evaluation.

At the associate professional level the work, while still keeping a sensitivity to the generic needs of clients and families, begins to take on more specialization in terms of more difficult technologies, more complex cases, a sub-field, or supervision or management. The workers generally have a broader orientation to community and organizational processes as well as to clinical processes, although this will vary with the kind of specialization expected of the job and in the setting in which the individual worker is employed.

Associate professional level workers may have developed this expertise through having extensive work experience, continuing education and training as technical level workers or through college training programs roughly equivalent to the baccalaureate level. In either case, associate professional level workers are expected to exercise program leadership and initiative while still being aware of their limitations.

Professional or Specialist Level

Professional level workers carry out both the ordinary and extraordinary work of the field and function as teachers, researcher/evaluators and administrators. They are the experts in their field. There are

further sub-specialties requiring advanced expertise beyond the basic professional practice level, but essentially the professionals are the top experts in an agency's program.

- Professional workers carry out the treatment and rehabilitation program for clients and families with both ordinary and extraordinary problems. They are skilled in working with complex problems and in the use of technically difficult strategies and techniques.
- Professional workers serve as consultants, teachers and supervisors for other workers in the system. Their technical expertise in clinical knowledge and skills carries this obligation, but it also carries the obligation for the professionals to be proficient in the skills of consultation, teaching, and supervision.
- Professional workers function to develop new knowledge and to evaluate a program's effectiveness and efficiency. This requires knowledge and skill in basic research and evaluation techniques.
- Professional workers may carry managerial and administrative responsibilities for significant program services in addition to clinical responsibilities. This includes administrative leadership responsibilities for entire units of a larger program as well as administration of independent programs. This also requires supervision of persons with middle level management responsibilities under their direction.
- Professional workers function as a major community developer of support for their programs and as change agents of community practices and resources to more effectively serve clients and families. This requires work at broad community levels--agencies, counties, cities and states.

Not every professional will play all of these roles upon initial employment, just as the other levels will not function in all roles at once; however, they are all roles which professionals may be called upon to play and for which they should be prepared at some basic level of competence. With experience and advanced training obtained through continuing or postgraduate education, professionals may acquire greater proficiency in any of these specific areas. Most professionals will

find themselves functioning relatively more in one or two of these major roles, depending on the agency's needs and the worker's expertise and interests.

Professional workers generally develop their expertise from taking formal courses of instruction in professional education programs at the graduate level, but they may gain their expertise from work experience.

It should be recognized that recommendations of this kind for various levels of workers apply to the functions and relationships of workers in *organized care systems*. There are other possible roles--especially for professionals--in independent practice, in full-time university teaching, in full-time research or in full-time administration at the level of major federal, state or county agencies. These are major sub-specialties or patterns that come from individual choices and often require considerable further training and experience.

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Chapter 4

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Chapter 5

RECOMMENDATIONS

This chapter presents a possible scheme for relating all of the various manpower segments of the mental health system to each other in a delivery system which has undergone major expansion and change as a result of society's broader expectations. We suggest the following patterns for training and utilization of the various professionals and paraprofessionals.

THE FOUR CORE MENTAL HEALTH PROFESSIONS

The four core mental health professions remain in key positions in the mental health manpower system. However, their functions have changed and are likely to change a bit more to provide for the design of a productive and integrated mental health delivery system.

Psychiatry

Psychiatry remains the profession with special expertise in the diagnosis and treatment of the major mental illnesses. It is a medical specialty which is very central to the treatment of the major biomedical and psychological illnesses. Psychiatrists must continue to play key roles in acute treatment settings and in active treatment programs. The traditional medical model of professional teams will remain appropriate for such settings as mental hospitals, psychiatric units of general hospitals, and day hospital programs.

Psychiatrists should also remain key participants in the diagnosis and therapy of the most difficult cases of psychoneurosis, personality

disorders, and other conditions, but this will often be as consultants or as members of teams rather than as the team leaders.

Most in-patient mental health treatment programs have either a medical director or a clinical director who directs the overall clinical program. The responsibilities of this person, who is usually a psychiatrist, are largely managerial, although they relate to the treatment programs. The medical or clinical director plans the overall program, organizes the staff, directs and coordinates the program, and evaluates its outcome. While only about half of psychiatrists work in organized care settings, the role of program director is a key one for those psychiatrists who are employed in organized systems. The preparation of psychiatrists should anticipate this role and training for such leadership roles should be provided.

Beyond their roles in acute treatment settings, psychiatrists must always be available as major consultants for any mental health program where their involvement will vary from setting to setting. If the program is one of long-term care of the mentally ill, psychiatrists will surely be involved in periodic review of progress, in reassessing the treatment plan, and adjusting any medication orders. In these cases and in programs serving the lesser mental and emotional disorders, psychiatrists will very likely function as team members and as consultants to other workers in the system. The program and teams may be led by someone from one of the other professions, but the expertise of psychiatrists is still essential and must be readily available.

Psychiatrists must understand these team and consultation roles as important ways in which they can extend their expertise to more

patients/clients without necessarily directing the team or prescribing the entire program. The preparation of psychiatrists should stress the skills of consultation and team participation when the team model is other than the medical model.

The expertise of psychiatrists requires that they serve as teachers and supervisors for other professionals and middle level persons on the staff. There are many times when psychiatrists will be called upon to teach in staff development programs for their own agency or for staff persons of other community agencies. This teaching may be done in formal didactic teaching sessions, but it is likely to be more effective in problem-oriented sessions that make use of adult education principles. These educational skills should also be included in the training of psychiatrists who are expected to work in organized delivery programs.

Some psychiatrists function in top administrative positions in mental health programs at local, state, and federal levels. For the most part these individuals choose these positions by virtue of their professional interests and abilities. There are specialized continuing education academic programs to train top level mental health administrators which should continue and be strengthened. There appears to be little need for *all* psychiatrists to be trained for this level, however, the basic psychiatric residency training programs should provide enough understanding of the specialty of administration so that all psychiatrists can appreciate what is taking place in the administration of the programs in which they work and so that they can intelligently decide whether mental health administration is a specialty which they wish to pursue personally.

Psychiatry has so far made little use of physician extenders, such as physician's assistants and nurse practitioners. In light of the impending cut-off of foreign trained physicians who will be permitted to take residency training in the United States under the Health Professions Education Assistance Act, psychiatrists in long-term care mental hospitals should consider making more extensive use of physician assistants, nurse practitioners and clinical pharmacists, especially for conducting routine physical examinations, tending to minor physical illnesses, and assessing the needs for medications for long-term patients.

Psychology

Clinical psychologists and the related specialists in counseling psychology and community psychology, have moved into a central role in the mental health manpower system. Psychologists have continued their expertise in assessment of mental functioning (psychological tests of intelligence, memory, personality, learning ability, social functioning, etc.) and in research, while they have acquired additional skills in a range of psychological interventions. The most notable of these are the behavioral therapies which were largely developed by psychologists. These approaches are uniquely appropriate to psychology's concern with objective measures of behavior. In addition, however, psychology has pioneered with other therapies, such as biofeedback.

Psychological assessment skills are necessary in all mental health programs and psychologists must always be available for such services. However, psychologists' therapeutic skills have become much more significant for the range of psychosocial conditions which are now commonly seen in mental health programs. In many situations the therapy is

carried out by psychologists, but in most programs the major role of psychologists will be in designing programs of therapeutic intervention (especially behavioral therapy regimes) which will then be carried out by other workers in the system, with periodic evaluation and adjustment by the psychologists. This kind of expertise is as essential to a mental health program as that of the psychiatrists.

The role described here is more that of a consultant and team member than that of a direct case therapist. The training of psychologists should prepare them to be expert team members and consultants with knowledge and skills of group dynamics and leadership. Even in the work of assessing clients' mental functioning, psychologists must be aware that their assessments and recommendations are done to assist a team and its members in planning and carrying out programs for clients--not just for assessing the clients' functioning in abstract form.

Psychologists will frequently be called upon to serve as team leaders and supervisors for unit teams in which the problems are largely psychosocial. Other kinds and levels of workers then carry out the team's plans for individual clients. Thus, psychologists need the same kind of training in team leadership and supervision as that described for psychiatrists. Psychologists have not traditionally been trained for these roles.

Psychologists in organized delivery programs will often find themselves in administrative leadership roles in relation to major units of an overall mental health agency (e.g., an adolescent unit, a consultation and education service, a hot-line program). This role requires skills in management and administration of such a program with all the

components of program planning, organizing, directing, coordinating, and evaluating. The training of clinical psychologists for this area of managerial competence has generally been deficient, and this must be corrected by training programs.

Because of their competence in scientific measurement and research, psychologists will be expected to play major roles in community assessment of need for mental health programs and in evaluation of the programs once set in place. These are important roles for psychologists. However, it is important that the training of psychologists for this role stress the differences between traditional experimental research, which is the usual orientation of academic psychologists, and program evaluation, which uses some of the same techniques of measurement, but applies them to ongoing program management rather than to carefully controlled experiments.

Psychologists should also be expected to participate as teachers in staff development programs for both the mental health agency and for other human service agencies to help them to better recognize and understand the mental disorders and programs of mental health prevention. The development of skills for conducting adult education should be a basic part of the training of clinical psychologists.

Psychologists will often be the staff persons of the agencies who are called upon to develop programs of primary and secondary prevention. This results from their community assessment skills and their ability to plan programs of this kind with specific and measurable objectives. In actuality most psychologists have had little training that is oriented to strategies of primary prevention, but this

competence should be added or strengthened in the basic curriculum for both clinical and community psychologists.

A number of psychologists will rise to positions of top administration leadership in local and state mental health agencies. As in psychiatry, this will largely result from individual interests and talents which best be developed on the job and in continuing education programs especially designed for training in top level mental health administration. Here too, the basic education of psychologists who are expected to practice in organized mental health/human service systems should include sufficient understanding of administration so that each practitioner understands the administrative processes involved in his/her own agency and so that each individual psychologist can make an intelligent choice about whether to choose top level administration for his/her area of specialization.

Up to the present, psychology has paid little attention to the development of middle levels of psychological practitioners. The profession should pay closer attention to the pilot efforts that are under way and provide guidance and support for these practitioners to advance their careers.

Social Work

Social workers must also assume key positions among the mental health professions in providing the expertise for understanding and working with the social, family, and community aspects of mental disorder. Persons with major mental illnesses have frequently upset their relationship with their families and neighborhoods to such an extent that major efforts are needed both with the client and his

family and with the community in order to make his re-entry possible. In any case, such efforts will almost always facilitate the social restoration of the client. In the lesser mental disorders, especially in family and marital counseling situations, the primary interventions are directed at modifying faulty family interactions as often as they are to intensive therapy with individual members of the family. Social workers also have expert knowledge of community resources and processes that can be brought to bear to help individual clients in their re-adjustment and that can be modified to help whole groups of clients and families function better emotionally.

Social workers will also conduct counseling and behavior change programs for individual clients.

Traditionally, social workers have carried out these activities with clients through their case work, group work, and community organization activities. These direct client oriented roles will remain appropriate activities--especially when the problems are especially complex or catastrophic. Since these situations can occur across the entire range of mental disorders, there always should be professional social workers available to respond to this need for direct practice of social work.

However, major roles for social workers, as with other mental health professionals, must be as team members and consultants to help formulate the treatment plan for clients of the team and then to consult with and assist the specific team member who assumes responsibility for carrying out that program. These roles will be especially important in the programming for long-term clients who are likely to retain some

mental or emotional disability as they move into the community. Social workers will be especially valuable in providing their expertise regarding community support resources and community process for mobilizing these resources. The training of social workers should include basic competence in these team-working and consultation skills.

Social workers will likely have supervisory responsibilities for other levels of social workers or of other kinds of mid-level workers. Continuing education in social work tends to be heavily oriented to the skills of supervision but there should be provision for training in this role in the basic professional education of social workers as well.

Social workers will also be called upon to teach in staff development programs for both the mental health agencies and for other human service agencies of the community. They, too, should have basic preparation in the skills of adult education.

Also, like the other professions, social workers, in addition to their clinical duties, are frequently called upon to be managers of services within overall mental health programs (e.g., the aftercare service, the consultation and education service, the community development activity). This kind of middle management skill is seldom routinely taught in professional schools, but is so frequently encountered by social workers in their work situations (especially in their second or third job) that a basic orientation to middle level management should be included in basic social work education.

Social workers will often be employed in top level administrative positions in mental health agencies. Presently the largest number of

community mental health center directors from a single profession are social workers. Like psychiatrists and psychologists, these individual social workers have come into top administrative positions by virtue of their individual abilities and interests. Formal training for this kind of top level mental health administration should be left to continuing education or special elective courses, but the basic social work curriculum should include sufficient orientation to top administration so that workers understand what administration processes are under way in their agencies and so that they can intelligently decide whether they wish to specialize in administration.

Social work is the most central profession in the broad human services. Only about 28 percent of the membership of the National Association of Social Workers are employed in mental health; the others are in child welfare, family services, youth services, corrections, rehabilitation, health services and aging. There is considerable movement of social workers from one of these fields to another. Because of this, social workers provide a rich linkage between mental health programs and the other human services. They must have special understanding and skills in working with the broad range of other professions and occupations who make up the personnel for all of the human services and for the range of different cultures of persons served by all of these services.

Psychiatric Nursing

Psychiatric nurses remain leaders in the acute hospital care of the mentally ill and in related programs, such as day hospitals and clinics. Even in these settings, most of the direct nursing care is

carried out by nursing personnel who do not have specialized training in mental health and psychiatric nursing. It is presently common practice for trained psychiatric nurses to play administrative and supervisory roles rather than direct nursing care roles. They frequently have responsibility for designing and supervising the therapeutic programs for a ward or service unit. This will be the proper responsibility for psychiatric nurses, and their training should stress the skills of program leadership and supervision as well as the skills of mental health and psychiatric nursing.

Statistics show that a large portion of trained psychiatric nurses work in either staff development programs or in nursing schools in which they teach psychiatric nursing. This is an important role, and one which should be anticipated by the graduate nursing programs and their students so that there is stress on the principles and skills for conducting adult education as well as on nursing skills.

Nurses have found fewer positions in general community mental health settings than the other professionals. Even in community mental health centers they have tended to function in the usual nursing roles in the in-patient or day hospital units. However, there are significant consultation and education roles to be played in community mental health programs--especially in regard to other parts of the general health system that also serve large numbers of mentally disordered persons (e.g., public health agencies, nursing homes, extended care facilities). These agencies are likely to have daily contacts with disturbed persons that require expert consultation from a mental health or psychiatric nurse. Many more mental health nurses could be used in consultation

programs directed to schools and youth programs. These consultation and education roles in relation to community workers should be expanded in the training and job descriptions of mental health and psychiatric nurses.

Nurses seem less likely to move into top administrative positions in community mental health, but there is no special reason why this should be the case. Training for top level administrative roles, as with the other professions, should probably be carried out in special interdisciplinary continuing education programs rather than in the psychiatric nursing education program, although there must be sufficient orientation to administration in the psychiatric nursing program for the nurses to understand the organizations in which they work.

There seems to be little tendency for nurses to become involved in the hard data activities of needs assessment or program evaluation. This may be appropriate in terms of evaluation of overall mental health programs, but it is unfortunate that this tendency often extends to the nursing services themselves. There is a serious need for more evaluative research and program evaluation of nursing programs. Much of the responsibility for broad scale nursing research will undoubtedly lie with doctoral level academic programs, but there should be sufficient stress on the basic tools of evaluation at the master's level so that all psychiatric nurses have the skills and motivation to do more evaluation of their own program activities and to participate in broader programs of nursing research.

OTHER PROFESSIONS

With the expansion of the scope of mental health and mental retardation programs, several additional social and rehabilitation professions have moved into the field. Most of these professions are not centrally involved in the diagnosis and treatment of the mentally ill and mentally retarded, but they are actively involved in the rehabilitation and restoration of clients, and in the therapy of several of the mental disorders other than the major psychoses and psychoneuroses. They should have significant roles in certain parts of the system.

Vocational and Social Restoration Workers

Among the major other professional workers in the mental health system are those whose work involves providing vocational and social training to assist and support the mentally disabled in their transition to community living. Some of these workers are more commonly employed in institutional settings and others in community settings. They include:

Occupational Therapists

Occupational therapists employ arts and occupational skills to engage the mentally disabled in either therapeutic or rehabilitative activities through which clients can express their emotions and develop more effective relationships. About 20 percent of all occupational therapists are employed in mental health or mental retardation settings. They frequently supervise the work of aides in occupational therapy shops or offer consultation and education to other team members who carry out ward or unit activity programs with clients.

Occupational therapists should be prepared to assume leadership roles enabling them to design the programs and then train and supervise other persons who actually carry them out.

Recreation Therapists

Recreation therapists use recreational activities to involve the mentally disabled in expressing their emotional conflicts and in learning new interpersonal and social skills. Their training is usually in therapeutic recreation, where they learn to assess the special needs of clients and the techniques for involving them in appropriate activities. There are also related specialists of art, music and dance therapy, each of which employs the special techniques of these specialties for assessing and assisting selected clients in their treatment and rehabilitation. These therapists almost always work as a part of a larger team in which their work is one facet of the overall program for clients.

They need the skills to work with other professionals to design an individualized service plan for clients, and skills for supervising other workers who in many cases actually carry out the programs, either through ward activity programs or through aides who work in the specialized recreation, music or dance program. These workers are unlikely to become major administrators of mental health programs, but they are administratively responsible for their specialized services.

Special Education

Special education teachers became major actors in the manpower system for mental retardation several decades ago, but they also commonly work in programs for the emotionally disturbed. They work primarily in the special education programs of the schools, but they are also

employed in institutional and community-based mental health programs for children. In both institution and community settings special education teachers are primarily responsible for the design and supervision of special training programs for the pupils. This involves assessing student needs, working with other professionals on the team to design a program, and then teaching and supervising other workers on the team or teacher aides in the classroom where the programs are carried out. Thus they, too, must function more as program planners, consultants and supervisors than as direct teachers. This will become even more common in public schools where the requirement is to "mainstream" the emotionally disturbed and mentally retarded so that the special teacher becomes a consultant to the regular classroom teacher in the education of the handicapped in the regular classroom.

Vocational Instruction and Counseling

Vocational instructors and counselors are found primarily in vocational rehabilitation programs, but a surprising number are employed in mental health agencies, especially in those parts of the program that are concerned with the rehabilitation and restoration of clients to the community. These professionals do vocational assessment, training, counseling, and job placement of clients. They are especially likely to be found in transitional programs, sheltered workshops, sheltered employment programs, and in social rehabilitation programs for the mentally ill and retarded. These programs also should and do make extensive use of middle level workers for whom the professionals develop the plans and provide the consultation and supervision.

Vocational counselors will often become the administrators of transitional mental health programs in which these services are performed. Thus, they need understanding of the principles and skills for managing these intermediate sized programs, as well as of the skills for working with other professionals in the design and execution of programs of overall rehabilitation and restoration.

Social Group Work

Social group workers are experts in the design and conduct of programs of group development, leadership, and participation to help emotionally disturbed and mentally retarded persons improve their interpersonal and social skills through active participation in group processes. Group workers are employed both in institutions and community programs. At times they are actively involved in organizing and developing social groups themselves, but more often they function as consultants to other team members in the use of groups. Thus they also function as consultants, teachers and supervisors, as well as direct client workers with the groups which they personally conduct.

Interpersonal Counselors

There is also a group of other professionals who function as interpersonal counselors rather than as social and vocational restoration workers.

Counseling and Guidance

The specialty of counseling and guidance developed largely to meet the needs of schools and industry, where the majority of these workers presently are employed. However, a good number of these

persons are also employed in community mental health programs.

In general, they work with clients who have less serious emotional problems, including marriage and family problems. The specialty of marriage counseling is part of the counseling and guidance profession. While most of the work of these specialists is with individual clients or families, they also carry out consultation activities with other professionals of the communities (e.g., physicians, teachers, judges).

Relatively little is known about what supervisory or administrative work is carried by these workers since they are not usually separately identified in statistical reports of staff activities. Most of their work seems to be in out-patient programs, where they do direct clinical work.

Pastoral Counseling

Pastoral counselors are clergymen who specialize in the counseling of persons with emotional problems. The greater portion of pastoral counselors are employed by churches or pastoral counseling programs, but a number have been employed in mental health and mental retardation programs. In community programs the pastoral counselors carry out the same kind of interpersonal counseling that is done by other professionals, except that their work also tends to stress personal and family counseling rather than work with severely disturbed clients. However, they do often work with disturbed clients with strong religious backgrounds, but usually as a member of a team in which the program is guided by a mental health professional.

Pastoral counselors, like other counselors, usually do not come into managerial or top administrative positions in mental health programs. While they do some consultation, it is largely with the client's own clergyman rather than a range of other professionals or agencies. Their role thus seems generally limited to direct client services.

PROFESSIONAL ROLES IN GENERAL

From these descriptions of the roles and functions of the mental health professions and other related professionals, it appears that there are and should be certain commonalities:

1. Each profession has its own area of expertise which is needed by patients/clients in some part of the mental health **system**. These areas of expertise should be highly developed and respected.

However, it should be recognized that it is inefficient to expect the professionals to deliver their expertise to clients only in the direct clinical relationships in which they have traditionally been trained. Rather, they should often provide their expertise through team relationships and consultation relationships to other workers who will provide the direct services.

2. The professionals should apply their expertise in direct patient/client care mainly for the most difficult and complex cases, or cases in which there is considerable risk involved to the clients if the job is poorly done. This is partly to provide their special competence and partly to provide legal assurance that the highest level of expertise was used in these cases. For other conditions the professionals should seek other roles as consultants, teachers, and supervisors.
3. The professionals of all human service disciplines require clinical knowledge and skills that are common to all of the professions, and these common skills must be regarded as being important in working with clients as the unique skills of the individual profession. It is rarely to the patient/client's advantage to be referred to a succession of specialists, each focused on a unique technology. In team relationships, one team member should maintain primary responsibility for each client, making necessary use of

referrals, but ordinarily providing the continuity himself or herself by consulting with other specialists as needed.

4. Teams must have the expertise of all professions available, but not every profession should be directly involved in the delivery of services to the clients. In the acute stages of mental disorder, the professions will be more directly involved in assessment of the patient's need and in planning a treatment program. After that shift to a single team member--who may be one of the professionals or a para-professional worker--the professionals provide consultation and supervision.
5. Most professionals should expect to carry supervisory and basic managerial responsibilities. At present, virtually all of the professionals find themselves in supervisory positions and/or in positions in which they have both clinical and managerial responsibilities for a small unit of a larger service or for a small independent service.

This kind of middle level program management responsibility for some unit of a larger program is becoming increasingly common as mental health programs become more dispersed and community-based. In such instances the professionals play both clinical and administrative roles and should be prepared for both. This is not the same kind of administrative skill that should be expected of top level mental health administrators in that it does not deal with large administrative systems, obtaining of outside resources, elaborate personnel or accounting systems, public relations, etc. It does involve skills of supervising, organizing, directing, and motivating a small group of workers, planning and evaluating small programs, preparing budget requests and reports for such programs, etc. More work needs to be done to identify the elements of the kind of management that might be expected of any mental health professional after a couple of years of employment, in contrast to the knowledge and skills required for top level agency administration.

6. Top level administration of mental health programs may become the responsibility of persons from any of the professions. It is likely that psychiatrists will often become the heads of mental hospitals and of overall state or county mental health programs, but other professions will increasingly lead community programs and programs devoted to psychosocial and rehabilitation activities. It is doubtful that such top administrative principles and skills should be taught in the basic professional

education of the professions, except as electives for those persons who plan to enter this kind of work. However, there should be enough training in overall organizational and administrative theory in basic professional education so that the graduates have an understanding of the administrative processes under way in the agencies in which they work. This is especially true if the professionals are expected to work in organized mental health delivery systems rather than in independent practice.

7. Virtually all of the mental health professionals will function as teachers and consultants to other workers in their own agencies and to community workers of related professions and occupations. These are appropriate roles for which the professionals should have at least basic competence in addition to competence in their specialty's knowledge and skills.
8. A great deal of the work of mental health professionals in organized mental health delivery systems is related to programs of primary prevention, early case detection, rehabilitation, and other "program" functions, in contrast to the more traditional client "treatment" functions which have been stressed in professional education. These are functions for which any of the professions should be the leaders, but leadership will depend on developing the appropriate expertise. The professional schools have tended to overlook the theories and techniques for developing effective programs of these kinds. Steps must be taken for the professional schools to incorporate at least a basic minimum of this kind of knowledge in basic professional education. At present it tends to be offered mainly in continuing education programs which reach only a small number of highly motivated persons, and this is not sufficient for the leadership the mental health field requires.

THE PARAPROFESSIONALS

As already noted, the paraprofessionals have developed through two streams, one closely related to the individual professions, and the other related to the overall field of mental health and to the generic human services. These two streams should both persist.

The Profession-related Paraprofessions

Those paraprofessional programs that have grown in close relationship to one of the established professions have a certain advantage

in having a title which is already understood by society, even when the profession itself regards the lower level workers as aides or "sub" professionals. These workers will continue to be needed in those situations in which the services are organized by professional departments and in which the more traditional forms of teams are used. They should continue to be supervised by their respective professional supervisors but an increasing number should be used in more creative roles, especially to help extend the profession's technologies to clients and families in their own homes.

More work needs to be done to create career ladders for these workers so that they can move up both in the educational career system and in the personnel systems of the agencies. Too often colleges do not allow transfer of credits from one academic level to another, especially between different colleges. Thus, these middle level positions tend to become dead-end jobs. This should be improved by focusing career advancement on the basis of competence which may be gained through either work experience or academic training rather than on academic degrees alone. Some developmental work is being done along this line, but much more is needed.

Paraprofessional workers in technical and associate professional levels within the individual professions need more recognition and support by their own profession. Often they are denied membership rights in the profession, and thus there is no mechanism for certifying or registering them. Even when there is some certification or registration, the process tends to be controlled by members of the

profession itself rather than by the new workers. This needs careful scrutiny and modification.

It would appear advantageous for the full professionals to encourage the support of individuals entering the profession through the paraprofessional route, since many of these workers are minority group members or persons from rural or other underserved areas--all groups that the professions are having difficulty in recruiting. In addition these persons have a strong identification with the profession and have functional competence which is important to the profession's overall performance.

The Program-related Paraprofessionals

The other stream of paraprofessionals, those who are trained and titled by the overall program field of "mental health" or "human service," provide another set of issues. These workers tend to be trained as generic workers rather than as aides to any of the professions or as workers assigned to specific technologies. These generic roles are desirable roles in many situations--especially in community work in which the clients need help with many aspects of their psychosocial adjustment and need assistance in keeping all of the aspects of their therapy integrated. This is the need in aftercare for the chronically mentally ill and the mentally retarded, but it is also often a need of children, the aged, alcoholics, drug addicts, and others. Paraprofessionals may be the ideal persons to help motivate these clients and families to participate in the programs agreed upon by the overall team.

Paraprofessionals trained by field to function in the generic model are especially appropriate in certain situations:

In rural areas and in satellite programs of urban programs where there are likely to be fewer professionals;

In smaller programs that are less bureaucratic and traditional;

In programs that are organized into functional units and teams rather than those that are organized by profession;

In programs with a psychosocial and rehabilitation focus, rather than those with a biomedical focus;

In long-term community-based programs, rather than in acute care and institutional-based settings.

There are many possible variations in the generic worker model so that workers should sometimes be expected to play a large number of the functional roles, while at other times their jobs will be more limited. Some paraprofessionals should be expected to carry out only direct client care roles, while others should be expected to play additional community-oriented roles in the neighborhood in which they work.

At the very beginning of employment, entry level workers may be assigned and trained in limited tasks and roles until they gain a wider range of competencies. Further on-the-job training will expand their capabilities and the scope of their jobs and allow them to function in more independent roles as increased competency is demonstrated.

These workers have less occupational identity than paraprofessionals who are associated with one of the established professions. Society has less understanding of just what they do. There are

organizations of such workers which should help develop a sense of occupational or professional identity. There should also be a certification program for these workers based on clearly specified competence so that employers, professionals and educators can know what they are competent to do.

Within the specialty area of mental health there might be several different sub-specialty paraprofessional worker models. There are already "alcohol counselors," "drug abuse counselors," "community mental health workers" and "mental retardation workers." Other possibilities might be "child mental health workers," and "geriatric mental health workers." All of these workers should work with their clients and families in generic models with sub-specialization in relation to the particular kind of client or problem they serve. All of these mental health workers are closely related to similar workers in other human service fields, such as "aging program workers," "correction workers," "child care workers," and "health counselors." They require many common skills, and they depend on a common body of knowledge which they apply to help their clients and families improve their bio-psycho-social functioning. There is considerable merit in all of these groups seeing themselves as "human service workers," rather than seeking independent recognition within the specific program fields in which they are employed.

Chapter 6

IMPLICATIONS

These suggestions for a more systematic plan for the relationships of the various professionals and paraprofessional workers in the delivery of mental health services have significant implications for each of the component parts of the mental health delivery system because, in the end, all of these pieces must fit together. It will not be sufficient to make only isolated changes in one or another of the parts, just as it has not been sufficient to create new paraprofessional workers while leaving the training and functions to professionals essentially unchanged. These, then, are some of the implications of this overall blueprint for integration of all the professionals and paraprofessionals in mental health.

IMPLICATIONS FOR CLIENTS, FAMILIES AND COMMUNITIES

There is considerable evidence that clients and families often do not feel well served by the system of mental health professionals as they are typically constituted. In regional hearings, the President's Commission on Mental Health received extensive testimony about gaps in services, turf battles between workers, and inefficiency. Data show that the largest proportion of clients visiting community mental health centers come for only one visit. Many come for evaluation only, but many others find their needs are not met so they simply drop out. In addition, there are many areas of the country--especially rural areas and inner city ghettos--where services are not available or not accessible.

A manpower system that employs a range of different kinds of professions and different levels of workers will more likely be able to extend services to outlying areas of the communities--especially if the new workers are given outreach and community support roles rather than aide roles in institutions and mental health centers. In many cases the clients will feel more comfortable with paraprofessional workers like themselves. A New York City study showed that paraprofessional mental health workers were much more acceptable to former hospital patients in aftercare programs than were the full professionals.¹

Long-term clients who are mentally ill, mentally retarded or aged need a single person in the mental health manpower system to whom they can turn and can trust to help them with all aspects of their treatment and rehabilitation. Such workers will often be paraprofessionals who function as members of a team in which there is ready access to the expertise of the professions.

Clients and families will feel more comfortable in working with a worker who will be concerned with the totality of their problem, and they will often be better able to understand the language of these workers than the abstract terminology of many of the professionals. In many instances the paraprofessionals "speak the same language" and come from the same neighborhoods and cultural backgrounds as the clients and, thus, have a ready understanding of the values and social pressures of their clients which they can use in representing clients' feelings and needs in consultation with the full professionals.

The jobs of community-based mental health workers will often include outreach, advocacy and linkage to other agencies and services. These services have not traditionally been provided by mental health professionals. For the most part mental health agencies have seen only "well motivated" clients who could come on a continuing basis for therapy in the clinic or offices of the professionals during regular working hours. Many potential clients have been unable to make this kind of adjustment in their lives in order to avail themselves of such therapy, but a community-based paraprofessional, free from such traditional restrictions, should expect to meet clients at times and places that are convenient for the clients, and help them make contacts with other agencies to obtain services and resources that they need. Such a relationship will help the chronically ill, the retarded, the aged, etc., to keep in touch with the services they need rather than expecting them to do it all for themselves.

Neighborhood consultation and prevention programs will also be better served by having a single worker assigned on a continuing basis, and the continuity of a relationship with a single worker will more likely lead to community development than arrangements that send a different worker on each occasion.

IMPLICATIONS FOR WORKERS

For all workers, professionals and paraprofessionals, such a scheme for relating the various kinds and levels of workers represents a way of extending the expertise of the professionals to as many clients as possible. This requires understanding on the part of all. Such a

pattern must not be seen as an effort to take over any profession's prerogatives or to undercut the need for expertise.

Professionals

It is particularly important that professionals see such a pattern as a way of extending their expertise to a larger number of clients in a different way from that in which they have characteristically been trained to practice. This will be difficult for many practitioners who have been trained to believe that they, and they alone, are qualified to deliver direct care services to clients. The professionals will have to develop the skills of working as team members in which they establish an overall treatment plan for clients but then turn over the work of actually carrying out that program to other workers, often paraprofessionals, retaining a "hands-on" responsibility for the work, but not necessarily a "hands-in" role. The direct client care relationship will continue to be a professional responsibility for the most difficult or complex cases, but in organized delivery programs the professional role generally becomes one of assisting other workers to deliver the direct care services while providing consultation, and program leadership. The professional also has responsibility for staff development (teaching) and for evaluation of the effectiveness of the program's activities.

Studies show that these roles and functions are already the patterns that professionals assume in mental health agencies. Thus, there is nothing really new in this pattern. What perhaps is new is that these should become the *acknowledged* roles of professionals. Too often, at present, professionals move into these leadership roles with

a certain reluctance and remain apologetic for having "abandoned" their true professional work. Instead, professionals should be prepared for and anticipate these roles and responsibilities.

The professions will also have to develop skills of middle level program management and anticipate functioning in these roles. In most professional schools the focus of training has been almost exclusively on direct clinical work with clients (diagnosis and treatment). There has been little attention in the training years anticipating roles as program leaders, although many studies show that very soon after employment (sometime in the first job, but usually in their second job) professionals are assigned to significant administrative and/or supervisory duties in addition to their clinical responsibilities. While a few professional schools (especially schools of social work) provide elective courses in administration, these are likely to be oriented to top-level agency administration (e.g., budgeting and accounting, obtaining resources, personnel systems administration, management information systems, etc.) rather than to the kind of small program or middle management responsibilities that professionals are most likely to be called upon to carry out. These responsibilities include program planning and evaluation for relatively small programs, development of teams, organizing, motivating and controlling small numbers of employees, budgeting, managing and reporting of expenditures and activities for a unit or service of a larger program, etc. The basic concepts of administration may be the same at both levels, but the scale and operating realities are quite different between the management of a unit or service of a larger program and the

administration of an overall community mental health center, mental hospital or state mental health agency.

The professionals should also assume a more embracing posture relative to paraprofessionals. For those paraprofessionals who are related to specific professions, there should be open recognition and support from the professions, recognizing that the public will judge the profession by how well the entire profession serves them--not just the top professional levels.

Efforts should be made by the professions to expand the roles of the paraprofessionals beyond those of aides or assistants who work only under the direct supervision of professionals into more creative roles that expand the expertise of the professional rather than simply assisting. Thus, the combined productivity of the professional and the paraprofessional is greater than what each might do alone. It is a relationship in which "one and one equals three."

In relation to the paraprofessionals whose training and work is for the broad field of mental health, the professions should recognize that these workers also represent a source of recruitment to the individual professions as they advance in their careers, for the knowledge and skills which these workers use is the same as the generic knowledge and skills of the individual professions.

The professionals must keep themselves readily available for consultation with these paraprofessionals, just as they do for the other professionals or colleagues from their own profession. Studies show that there is likely to be greater trust and better utilization of generalist paraprofessionals in rural areas, in inner city satellite programs

and in programs such as those for the aged or alcoholics in which there are fewer professionals but a higher quality of supervision and acceptance.

The professionals should avoid the tendency to use paraprofessionals only for the less convenient or more choresome tasks or for work with less prestigious clients for it is often the less appealing clients and tasks which require the greatest professional expertise.

Paraprofessionals

For the paraprofessionals themselves there are several implications. For new kinds of workers in any manpower system several needs have been identified:

An occupational title;

Some kind of occupational group identity;

Work with meaning and dignity;

Security and recognition;

Specific skills, but skills that are applicable in several job settings;

Responsibility for a definite area of work;

A range of decision-making authority;

Training that is relevant to their job;

Variety in work experiences;

Promotional opportunities;

Appropriate salaries;

Appropriate supervision.

So far the issue of occupational titles and group identity have been only slightly addressed. Much of the paraprofessional movement has

stemmed from local individuals or agencies, rather than from the professions or from any coordinated national movement. The workers themselves have limited incomes and few opportunities to attend national or state level organizational meetings to establish their own identities as the professions do. There are several state and national organizations (e.g., National Association of Human Service Technology, National Organization of Human Services), but they have very few resources compared to the professions. In addition those paraprofessional groups that are allied to one or another of the professions have often been excluded from full membership in the professional organizations, and their programs of recognition have tended to be dominated by the professionals.

Occupational titles are variable across the country. Terms such as "Mental Health Workers," "Human Service Workers," "Mental Health Technicians," "Mental Health Associates," "Mental Health Assistants," "Alcohol Counselors," "Mental Retardation Workers," "Community Mental Health Technicians," "Psychiatric Technicians" are all common. To an extent these variations represent the uncertainty about how broad or how narrow the field should be for these workers. There is need for greater uniformity of title.

In addition, more work is needed to give these workers better occupational recognition. Efforts are under way to develop certification programs for these workers based on the knowledge and skills that are required for the typical work which they do. These credentials need to be based on demonstrations of competence rather than on attainment of academic degrees so that they will provide

flexibility for workers to be recognized, regardless of how they have gained their expertise.

The work of a generic paraprofessional worker is likely to offer more personal satisfaction to the worker and increases the sense of commitment more than a job related to specific tasks. There is endless variety in the needs of the clients such a worker serves, and there is no end to the work to be done. In such a relationship there is never a time when the worker "has nothing to do" because his tasks are all completed.

At this time, salary levels and career opportunities are poorly developed. There are wide variations in salary levels depending on local interests, and there has not been enough experience with new levels of workers for operational career ladders to have developed in most agencies. As clearer guidelines develop for the paraprofessionals and as credentialing processes are put in place, there will very likely be more uniform and satisfactory classifications of these positions and more clearly established career systems. Paraprofessionals and their leaders need to be in the forefront of efforts to establish adequate salaries and career plans.

The matter of career advancement for paraprofessionals will depend on continuing education to advance to higher levels and into the established professions. Studies show that as many as 50 percent of the graduates of Associate of Arts level programs are already taking additional course work on either a part-time or full-time basis to advance their careers. Up to 70 percent of these persons indicate their intentions to pursue further education. For many persons this

requires working full time or part time while also attending college. The paraprofessionals must press to assure that such educational opportunities are available, and also to assure that continuing education programs conducted by their agencies are open to them. Training workshops in subjects such as "Family Therapy" or "Group Therapy" are as valuable for paraprofessionals as for professionals.

Generic paraprofessionals will have the knowledge and skills to work with a variety of kinds of clients and families and, thus, should have considerable ability to transfer from one job or one city to another. However, lacking the support and endorsement of any single major profession, they will undoubtedly find resistances in some agencies that are structured according to traditional professional departments and, if employed in such agencies, will probably be assigned to one of the established departments to do the more restricted work of that department. They should anticipate this kind of situation and be prepared to make the appropriate adjustment and later modify their jobs through demonstrations of competent performance.

IMPLICATIONS FOR AGENCIES

Perhaps the greatest implications of such a manpower scheme relate to the mental health agencies. There has been little overall guidance for agencies to use in deciding what kinds of workers to employ or how best to deploy them. Some agencies have adopted the traditional medical model; others have chosen social or behavioral models. Some have used blends based on the inclinations of individual unit chiefs, and there has been a great deal of reorganization of staff from one model to another. Much has depended on the inclinations of the leaders at any particular moment.

There will undoubtedly continue to be variety depending on the nature of the particular service, the kinds of clients being served, and the availability of various kinds of workers. Based on the common knowledge and skills of all of the professionals and paraprofessionals, it is usually possible to interchange one for another as the primary therapist for clients as long as there is at least a minimum number of each of the professional specialists to provide the needed expertise for program leadership and consultation. The use of paraprofessionals is especially appropriate for programs of outreach and long-term community support, but also for day hospitals, day activity programs, socialization programs, and programs for special population groups, such as children, the aged and alcoholics and drug abusers. Paraprofessionals provide potential for extending the mental health program's services in rural areas and in areas serving inner city poor, since they are often well acquainted with the culture and language of clients in these areas and are readily accepted there.

The agency will need to carefully consider the objectives of each of its programs in order to plan the appropriate staffing pattern. This is especially true of outreach and community support systems. Recent court decisions require that mental patients be treated in the least restrictive setting, which is usually a community setting, and the decrees require that the mental health agencies provide long-term, outreach responsibility to assure that clients are getting along satisfactorily in these community settings.

Even more important for the agencies is the ability to set treatment plans with specific outcome objectives to be attained for each

client, rather than the usual plan which describes the services to be provided instead of the outcomes to be attained. Once outcome goals are set, along with the proposed treatment plan, it becomes possible for any one of several team members to carry out the plan, provided there is ready access to the expertise of all of the professional specialists when needed.

It is also essential that a specific decision be made regarding which member of the team is to be the primary therapist to carry out the program for each client. The criteria for this decision may be based on several factors:

The complexity or difficulty of the client's problem;

The primary nature of the client's problem (i.e., Is it a psychological, a social, a medical or a rehabilitation problem?);

The degree of risk to the client;

The location in which the program will be carried out (e.g., in-patient service or the community):

The preference of the client for the worker of his choice.

Because these are factors which require the application of professional judgments, there will be variations in which worker is designated to be the most appropriate person to be the case manager for each client. However, it is important that a designation be made, and that appropriate plans be established to supervise that worker's progress toward the goals.

In many ways this pattern of using a single worker to be the primary therapist to carry out the program for each client is exactly crosswise with the traditional patterns of mental hospitals in which each specialist carried out a narrow spectrum of the therapy for each patient. This

model of using small teams with primary therapist or case manager assignments for individual clients is more likely to fit in an overall organizational pattern that uses small service units (geographic units, day hospitals, half-way houses, etc.), rather than in large bureaucratic structures that are organized by professional departments. More and more mental health programs are being organized by functions or by geographic units as the mental health system has become oriented to the communities and concerned with rehabilitation and aftercare as well as with acute treatment.

The agencies must establish appropriate job descriptions, salary schedules, and career ladders for the full range of workers. Whenever possible, job qualifications and career ladders should be based on the competencies to be expected, rather than upon the attainment of academic degrees. This requires careful definition of the competencies and measures of performance that are truly related to effective work with clients. Workers should be able to enter jobs and advance on the basis of demonstrated proficiency which has been obtained either through work experience or through formal education. This notion which represents a departure from the traditional requirements of academic degrees and pencil-and-paper tests is being fostered by court decisions.

Agencies will need to establish staff development programs in which the professionals can be prepared for their roles as supervisors, program unit managers and teachers. Hopefully, these competencies will be added to the curricula for the training of professionals and paraprofessionals in the future but, for some time to come, it will be necessary for the agencies to provide them through their own staff development programs.

Finally, the agencies must provide greater attention to the utilization of all personnel. Many agency heads find that more precise attention to matters of goal setting, organization of the staff into units and teams, precise worker assignments, monitoring of progress toward goals, and incentives and rewards can increase productivity, efficiency, and morale. Such administrative attention does not require an authoritarian style of management, but it does require the same kind of attention to manpower that has typically been given to fiscal and data management. Active administration of staff may be upsetting to some persons who have developed familiar and easygoing patterns of operating, but if management changes are brought about by involving the staff in the study of personnel needs, goal setting and decision making regarding ways to maximize the impact of all staff in the delivery of services, the staff are likely to accept and welcome the change. All of this requires time and administrative skill to negotiate the changes in organization and procedures, but it can be expected to bring about more productive staff-to-staff and staff-to-client relationships.

IMPLICATIONS FOR PERSONNEL SYSTEMS

There are significant implications for personnel agencies in moving to a manpower system that employs a range of professionals and different levels of paraprofessionals. This is less of a problem for large personnel systems that work with a variety of agencies because they generally have had experience with such concepts as career ladders and proficiency testing in other fields.

Job descriptions now require greater definition of the specific competencies to be carried out so that appropriate procedures for selection and promotion can be prepared. Except for those professionals who are required to be licensed or certified employment qualifications can no longer be based upon academic degrees that cannot be shown to be relevant to specific job performance. Personnel systems are under court orders to make these changes. This will require special efforts to develop job descriptions for paraprofessionals whose jobs have previously been described only as aides to perform tasks as directed by the professionals. There will have to be much more precise description of the specific tasks and competencies to be carried out by workers at all levels.

Personnel systems will also have to develop new measures for competence based on performance. Such tests have been common for positions such as typists and truck drivers, but they have not been developed for human service work. Work is under way in many places to identify the specific competencies needed and to devise performance measures based on these competencies, although it is difficult to formulate procedures that are highly reliable. Much depends on how precisely the competencies can be described and how well other job-related variables, such as the attitudes and motivation of workers, can be identified and assessed. Much work remains to be done in these areas.

Another decision to be faced by personnel systems is whether to retain professional job titles for many positions or whether to go to titles that describe the functions the worker performs. The latter provides greater flexibility for personnel administration in most settings,

although professional titles may be required in acute treatment programs for payments to be made under third party health payment plans. Many personnel systems have already chosen to use functional job titles (e.g., Aftercare Worker, Transitional Services Worker, Halfway House Supervisor) and thus allow persons from several different professional backgrounds to qualify for the positions.

FINANCIAL IMPLICATIONS

There are fears in the minds of many professional persons that administrators, budget analysts, and legislators will see the use of paraprofessional levels of personnel as a cheap source of workers to replace professionals. On the other hand there is a tendency for many administrators to claim that they cannot implement any such changes without great new sums of money. Probably neither one of these situations is correct.

New levels of workers are perhaps best seen as a way to render services to more clients, rather than as a way to save money. Professionals are still needed to give competent direction, planning, supervision, and administration. In addition, the salaries for paraprofessionals, while less than those of the professionals, are still very substantial. Thus, for example, technical level workers should receive about the same salary as a beginning nurse (Associate Degree nurse). However, it is in overall productivity and effectiveness that a manpower system that uses both professionals and paraprofessionals will have its impact. This is especially true if there is creative and careful management of the whole manpower system so that the result is truly "one plus one equals three."

For the administrator, much of the cost of using new levels of workers can be found within existing budgets by shifting priorities and reallocating funds if the administrator is committed to finding a way to do it. Vacancies occur quite frequently in most organizations, and some of these positions can then be reclassified for new workers.

Funding may also be obtained from special programs, such as the community support program for long-term mental patients, and from alcoholism, drug abuse, and vocational rehabilitation funds. These are all somewhat restricted funds, but they do provide some opportunities for supporting paraprofessional workers in the overall mental health agency.

Special problems are posed by those health payment programs that restrict payments to programs that use only fully licensed or accredited personnel. This limits the uses of paraprofessionals in acute treatment situations until a recognized certification system can be established. Fortunately such restrictions do not apply to most aspects of the mental health system.

LEGAL IMPLICATIONS

At this time there appears to be little change in the legal liabilities in the use of a broader range of professionals and paraprofessionals. The liabilities are greatest in those programs that remain closest to the medical model in which the physician is considered to be liable for the actions of all of his agents (other professionals, nurses, aides, paraprofessionals, etc.). In these situations the liability will be no different from that at present. However, as program philosophies shift

away from medical philosophies to psychological and social models, it is presumed that the client is a more active actor in the process and bears some of the responsibility for the outcomes; thus, the total liability on the program is less. The responsibility lies with a broader team of workers including the client. This is more consistent with the case manager concept.

The pressures for licensure of various professionals have increased as a result of third party health payment programs that require independent providers to be licensed. Many observers feel that the current pressures for licensure programs by many groups (e.g., social workers, psychologists, marriage counselors, alcohol counselors, drug counselors, etc.) are not protecting the public as much as they are enriching the professionals. Most persons would prefer to see high quality certification programs based on demonstrated competence rather than additional licensure programs. Minnesota and a few other states have taken specific legislative action to limit the numbers of licensed groups. More states can expect to take similar steps.

The issue of confidentiality should pose no problem, since all professionals and paraprofessionals are trained to avoid breeches in confidentiality. There may be problems posed by certain clients who resist being seen by *anyone* from a mental health service although they need the services. All staff must be concerned about invading the privacy of such persons and being too aggressive in insisting that they receive treatment. The right of persons to refuse treatment has been affirmed in many court decisions--particularly in decisions against psychiatrists. Persons who are not clearly dangerous and who do not wish to be seen by mental health workers should be left alone.

IMPLICATIONS FOR EDUCATIONAL PROGRAMS

Implementing a mental health manpower system of several different professions and paraprofessions has several implications for educational programs.

Professional Training Programs

In professional schools the training must prepare the graduate for competence in the skills of supervision, program leadership, program evaluation, adult education, and consultation, in addition to the skills needed for direct clinical practice. More important, however, is to set before the students these *role models*, rather than just those of the clinical practitioner. The practicum portion of professional education should include experience in applying these skills as well as the traditional clinical skills. Too often students truly learn clinical skills through both classroom learning and practicum experience, but they only "learn about" supervisory and program skills through didactic lectures and readings. This must be remedied.

Competency in supervision, education, program management, etc., should become an integral objective of the education of professionals--not an elective which students may choose if they desire. Graduates need basic competence in these functions--not great expertise, but their knowledge and skills should be at relevant levels (for example, management and motivation of a modest team of staff workers rather than personnel administration for a state level agency).

In paraprofessional training programs in technical schools, community colleges and four-year colleges there is the need to design curricula that prepare practitioners with specific competencies. It is not

sufficient to simply provide an aggregation of classroom courses with little or no field training and with no clear notion of the skills to be developed or the level of proficiency to be attained. Many of the existing training programs are competency-based with a great deal of field training, but this is not universally true. There is need for greater consistency in the objectives and outcomes of these paraprofessional training programs. A national mechanism for approval of such educational programs according to generally accepted standards is under development. There must be provision for variation in programs but still there must be enough overall consistency so that all graduates have certain core competencies.

The colleges should engage advisory committees of local agency persons and practitioners to assure that the training programs are preparing graduates for the unique needs of the local agencies as well as for the generic career skills. Such advisory committees can help the programs to develop relevant field training and open up job opportunities for the program's graduates.

Both professional schools and the paraprofessional training programs must be prepared to do much more work in continuing education for their graduates. Not only do the workers need to keep up to date with new clinical technologies, but also with the competencies in team functioning, supervision, management, consultation, prevention, rehabilitation, adult education and program evaluation. These are generic skills around which continuing education should be made multi-disciplinary. Agencies providing continuing education programs for their staffs should insist that such programs be multi-disciplinary when they negotiate the contracts for educational institutions to conduct continuing education activities.

In basic professional and paraprofessional education programs there should be considerable emphasis on developing competence in those skills that are common to all of the mental health/human service fields as well as those that are unique to a single professional group. Among the common skills are:

- Basic interviewing and assessment skills;
- Counseling skills;
- Simple teaching;
- Group skills (organizing, leading, decision-making);
- Behavior modification skills;
- Interpersonal helping skills.

All levels of professional and paraprofessional education must give closer attention to the linkages between the various training programs. Arrangements must be simplified for the transfer of credits from one level to another so that there are career ladders in the educational system comparable to those in the employment system. This will require that each level of training program have a clear statement of objectives for the competencies of its graduates and how they differ from those of other academic levels.

Within the professional schools there are elective programs designed to prepare top level administrators for mental health and other human service programs. Some of these are full-time graduate programs; others are part-time or continuing education programs for administrators who find themselves already in top level positions which they cannot leave to take part in full-time educational programs. Both kinds of programs are needed to provide better preparation for top level persons who administer mental health programs.

So far these programs have stressed the knowledge aspects of administration (e.g., assessing needs, program evaluation, budgeting and financing, legal and regulatory factors) more than the management of people and change in human service systems. Much more research is needed regarding the most effective approaches to the management of manpower, and this kind of research should be a major function of advanced programs in mental health/human service administration.

Paraprofessional Training Programs

Such a broad "human service worker" conceptualization will provide easier linkages to workers in other fields, and for broader job mobility for individual workers. It will also make it easier for colleges to develop strong training programs based on the common competencies with elective courses and selected field placements for students in the specialty areas.

At this time there are numerous training programs for mental health/human service workers at the entry and technical levels. There are several training programs at the baccalaureate level but only a very few at the master's or doctoral specialist level. Virtually all of these training programs train their graduates for generic models of employment, but programs at the advanced levels tend to stress administrative skills as well as direct worker skills (e.g., community mental health administration or human service administration). This is an appropriate pattern. If an individual mental health worker wishes to advance his/her clinical competence, it would be most appropriate for him/her to cross over into one of the established professions which already offer in-depth training in clinical practice.

The advanced training programs in mental health and human services will provide substantial assistance to society by concentrating their training and research on overall mental health or human service program administration. The area of administration of complex human service delivery systems requires much greater depth than most of the existing programs provide. It is unlikely that the schools of the individual professions will ever be able to provide administrative training of the depth that is needed, but advanced programs in mental health or human services could make this the focus of their programs, as a few presently do at the master's and doctoral levels.

Such a pattern of advanced training programs concentrating on depth preparation for mental health or human service program development and administration will provide a channel for those persons from the professions who wish to pursue careers in administration to cross over and pursue such programs in depth.

GENERAL IMPLICATIONS

The manpower utilization patterns proposed here are really not drastically different. For the most part they simply acknowledge and affirm what has already been taking place in many agencies in response to the needs of clients and agencies. In many situations these patterns of personnel utilization have been established without general acknowledgment of the changes. What is proposed here is that these patterns be recognized and established in planning the manpower systems for mental health delivery systems and the training programs for the professionals and paraprofessionals that staff them.

The key recommendations are:

For Mental Health Agencies

- Assure that fully qualified mental health professionals are readily available to all aspects of the program, but plan to deliver a good part of the direct client services through other levels of workers by using professionals more as consultants, teachers, and supervisors than as direct care providers.
- Use full professionals in direct care relationships for initial assessment and treatment planning, acute treatment of the seriously mentally ill, and for the more complex and difficult problems.
- Use teams that assign the responsibility for carrying out treatment programs for individual clients to individual workers of the team. This improves accountability. For simple, uncomplicated cases this worker could be a para-professional worker.
- Expect full professionals and those at middle levels to play managerial/supervisory roles as well as clinical roles.
- Develop career systems for both professional and paraprofessional levels of workers, with identifiable tracks by which they may make career advances on demonstration of increased competence.
- Recognize that all the mental health occupations and professions have many common skills in addition to their areas of unique expertise. This provides for considerable interchange of personnel provided the specialized expertise is readily available when needed. The quality of the relationship between a worker and a client is frequently as important in achieving favorable overall outcomes for clients as the specific technologies used.

For Training Programs

- Assure that all mental health occupations and professions have training in team functions as well as in clinical skills.
- Assure that professionals have basic training in certain competencies which they are very likely to be called upon to perform in organized delivery systems; supervision, adult education, consultation, and middle level program management for small programs.

- Assure that all occupations and professions have basically adequate generic "people working skills" as well as skills unique to their own occupation or technology.
- Develop educational transfer arrangements so that individuals may move from one academic level to another with a minimum of cost and inconvenience in terms of lost credit, unnecessary course work, etc.
- Develop competency approaches for both teaching and testing so that performance competence will be assured.

For the Professions

- Recognize that the truly professional role in organized care systems is often a leadership role rather than a direct care role. Other workers can extend the expertise of the professional to more clients.
- Recognize and give leadership to the new levels of workers within the profession. Develop their roles for maximum service to clients.
- Stress the inter-professional functions of each profession as much as the separateness and uniqueness.
- Recognize and relate to the paraprofessionals whose training and titles are in the broad field of mental health or human services as well as those within each profession. Recognize that they are a source of recruitment for the professions.
- Both professionals and paraprofessionals will require greater sensitivity to the use of self-help groups and volunteers as resources for enriching the community support systems for the mentally ill and mentally retarded. Despite a sometimes anti-professional posture, these groups need, and will use, the assistance of professionals and paraprofessionals who approach them as colleagues rather than as clients.

Chapter 6

REFERENCES

1. Wildman, Robert W., and Wildman, Robert W., II. "The Psychologist as a Ward Administrator." *Professional Psychology*, Vol. 7 (August 1976), 371-376.